Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 24^{Day} 2010 1223 **Physician** Ethel Parkinson Carole /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Havre de Grace Harford Memorial Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 06/14/1941 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Min 1 ☐ M 2 🛣 F 69 Yrs Maryland Director 216-36-5600 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Yes 2 □ No Maryland Harford Aberdeen Directo 10g. Citizen of What Country? 10f Zin Code 10e, Street and Number USA 21001 702 Courtney Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 er then "natural", or ō 1 ☐ Yes 2 XNo Specify: Specify: White If Yes, Give Year or Dates: à 3 ☐ Widowed ♣ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other then *r any injury or other traumatic event, in a Med 2008. Elementary/Secondary (0-12) College (1-4or 5+) accounting accountant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes Wurm Alexander T. Argue 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 702 Courtney Dr., Aberdeen, MD 21001 Richard Parkinson (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Memorial Gardens 7/29/10 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature unaral service Licens 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A Aberdeen, Maryland 21001 Mus Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Stage **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physicien and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 💢 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 28a. Date of Injury (Month, Day Year) After this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) efter 4 Homicide within 24 hours eft To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0070234 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. UNION Ave HAVRE de GRACE, MO 21078 ERIN WAISER MO

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 272010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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		State Registrar	Cer	Certificate of Death Reg. No.					23502
Physicia	n/	Decedent's Name (First, Middle, Last)		_		Date of Dea Month	Dav	Year	3. Time of Death
Medic	al	Dora Jean 4a. Facility Name (if not institution, give street and number)		Ransom	_	July	21	2010	8:59 AM
Examin	er	4013 Sinclair Lane		4b. City, Town, or	Ltimore			ty of Death	
Funeral	г	5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	1	9. Birthp	place (State or Foreign
Director			51 Yrs.	Months Days	Hours Min.	027087	1959	Mary	and
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ırylan I-f sh jed a	cto		10c. City, Town or Loc		111			[1	0d. Inside City Limits 1 Yes 2 □ No
or 28g	Director	MD N/A	<u> </u>	10f. Zip Code	altimore		10g. Citizen o	Mhat Coun	
with th	Funeral	4013 Sinclair Lane		2121	2		U.S		ni y r
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27215-0036 Within 72 hours after giene. er than "natural", o t, the Medical Exam	Completed	3 U Widowed 4 U Divorced Year or Dates.		☐ Yes 2 🖾 No	Specify:		Specia	y:Blac	:k
752 ho	nple	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupa ind of work done do	ation <i>urin</i> g most of worl	king	16b. Kind of	Business Inc	dustry
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/lar	户	Norman Ransome Sr.			Doroth	Dix	on		
ire, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygene. iftem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a	nd Number or Rui	al Route Number,	City or Town,	State, Zip C	Code)
Py IV		Dennis Mason(son)		Meteor C	ct., Ba	ltimore	,MD 2	1234	
Dore		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispos cemetery, crem	sition (Name of atory or other place		Date	20c. Location	•	
altimore, mit. Page 1 and partment of Hea portant: If item y injury or other ce.		4 Donation 5 Other (Specify)	King Men			29/10			
Baltimore permit. Page 1 a Department of I Important: If ite any injury or ot		21. Signature of Funeral Service Licensee	> 21	dsephoda 40 N. F	•° FBT own ulton A	Jr. Fi	uneral ltimor	Home, MD	e PA 21217
		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line.	he death. Do not enter	r the mode of dying	, such as cardiac	or respiratory arre	est,		Approximate Interval Between
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Medical Examiner		resulting in death) Due to (or as a	consequence of):						
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VISION OF VICAL RECORDS, F.O. BOX 06 of Attending Physician: The law requires that the death certificative death. Director: After this certificate has been signed by the attending p in by the funeral director, page 2 should be detached for use as it.	Completed by					24a. Was a			osy findings available inpletion of cause of
The la	S					perfor	med?	death?	· —
VICAL ysiclan: s certific director,	Be	25. Was case referred to medical examiner?			ce of Death (Chec	k only one)			
Physical direction	<u>و</u>		t 2 ER/Outpatient		4 ☐ Nursing H	ome 5 Reside			i
ding th.	Certificate:	1 Natural 5 Pending (Month, Day, 2 Accident Investigation	Year) injury	28c. Injury work?	Yes 2 No	28d. Describe ho	w injury occu	rred	
al or Attending P a after death. In Director: After the din by the funera	ij	3 Suicide 6 Could not be 28e. Place of Injury	/ - At home, farm, stree			28f. Location (St	reet and Numi	ber or Rural	Route Number,
al Din		building, etc.	(Specify)			City or Town	n, State)		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. Where Funeral Directors After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of m	mination and/or investi	gation, in my opinior	 death occurred a 	t the time, date an	d place, and d	ue to the cau	ise(s) and manner stated.
To the vithin To the complete	_	only one) 3 Certifying Nurse Practioner: To the be 29b. Signature and title of certifier	est of my knowledge, de	eath occurred at the 29c. License			cause(s) and n		
		* Kell (1) - Matchell	MD	0689	272		1	3, 20	
2		30. Name and address of person who completed cause of dea	1		ye 1 ***				
		Kelly W. Mithell, no: 401 N. B		Baltinora	ND al	131			
Stat Registra	ς I	31. Daw filed (Month, Day, Year) 32. Registrar	s Signature						
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Sterler Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 23503 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 13^{ay} July 2010 5:50 P M Jack Stevenson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Future Care - Lochearn Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Davs Hours June 12, Year 924 North Carolina **Director** 228-34-5661 86 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at Director 10d. Inside City Limits 1 XX Yes 2 No Baltimore MD 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 3513 Reisterstown Road 21215 or items 72 hours after death Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian "natural", or iter Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates Mental Hygiene. marked other than "natura natic event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools custodial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked or traumatic eve ဂ္ Miller Stevenson Ada Mason permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumat once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria Sullivan - sister 5515 Wilvan Avenue; Baltimore, Maryland 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ₭ Other (Specify) in state Signatu Wado Service Lic 25 teated Artesto Frylity Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final and Death Ph sician/ disease or condition resulting in death) evere Medical Due to (or as a consequence of): Examiner nwitty Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) Month Day Pregnant at time of death Year 4 ☐ Pregnant 9 ☐ Unknown signed by the a Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I autopsy 2 🗌 No Yes 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work? 1 X Natural 5 \square Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fi 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title o ဂ္ 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address son who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) 32 Begistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Physician/ Stacy Swinson 2010 0233 М Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel . Social Security Number If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Dec. 22, 1926 Hours 1 ★ M 2 □ F 244-38-0648 North Carolina 84 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits hours after death with the Maryland Director 1 ☐ Yes 2 🔽 No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 1404 Stonehurst Drive 21409 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. ^{Specify:}White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
?7 is marked other than "I N/A College (1-4 or 5+) United States Elementary/Seconday (0-12) Microflim Processor Department Of Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emma Caroline Futrell Swinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 1404 Stonehurst Drive, Annapolis, MD. Rene Lagana / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Mary Pearn den Verte etternisce) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Cemetery Crownsville July 27,2010 Crownsville, Maryland ≅gnature → Funeral Service Licens 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. 328 Sulphur Spring Road. Arbutus.MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Enysician/ aechac disease or condition) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Yes 2 No ed by the 9 Unknown 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate 1 ☐ Yes 2 ☐ No Yes 21 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending work? within 24 hours after death.

To the Funeral Director; Af completed filled in by the fun 2 No Accident Investigation 2 Acciden
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Fortifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and addre of person who completed cause of death (Item 23a) (Type, Print) MO 21401 31. Date filed (Month, Day, Ye 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 23505 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:55 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death timore Secours HUSPit 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Min. (Month, Day,) 9 18 Months Days Hours Year) Director 213-86-3936 49 61 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Fyamina Tental Control of the Control of the Medical Fyamina Control of the Control of the Medical Fyamina Control of the Contr 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director NA MD Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3123 Brighton Street 21216 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. δ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Black 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Laborer Various Jobs na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eugene Brunson Gertrude Durant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Gertdell Granter-Sister</u> 605 <u>Wildwood Parkway, Baltimore, Md 21229</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/3/2010 Western Catonsville, Md Signatur of Fure al Service Licensee 22. Name and Address of Facility
March F/H West 300 Wabash Baltimore, 21215 Ave 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical Multi-DISA disease or condition resulting in death) Due to (or as a consequence of) Examiner hours enorthy; c Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the bunal-transit Hospital or Attending Physician: The law requires that the death certificate be executed hours that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No 4 Pregnant : 9 Unknown Pregnant at time of death Month Day Year signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P. Completed by 2 No 3 Probably 4 Unknown 1 🗋 Yes After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? pre-hospital 24a. Was an autopsy perform 1 Yes 2 No Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work' 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 66108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. 2000 Baltinosa

State

Registrar

31. Date filed (Month, Day, Year)

JUL 28 2010

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 23506 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 35 PM Medical 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospital Baltimore 61 Baltimore If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 6. Sex 7. Age (In yrs. last birthday) 9., Birthplace (State or Foreign **Funeral** 1 □ M 2 🗷 F 237-90-0292 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** HIMORE 1 ¥ Yes 2 ☐ No LARY LAND 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? wania 21201 AUE 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed Specify: AMERICAN 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kin of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Services Koadaa Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H ρ OR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 st Department of Health ar. Important: If item 27 is: PENNSYlvania ave-Battimore Mil meed Daughtel Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Atonsuille MARUAND 4 ☐ Donation 5 ☐ Other (Specify) 2010 e of Funeral Service Licensee 2. Name and Address of Facility
AUCY M. WAllace Funeral Service
3405 W. FRANKLIN Street Baltime BAILIMERE MARYLAND 21229 23a. Part : Enter the disease, or complications that caused shock, or heart failure. List only one cause in each line. sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between OXIC Brain Opset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown iabe re 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 2 No 1 \square Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: ၉ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this eral Director: After thi filled in by the funeral 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at work? (Month, Day, Year) 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d

To the Funeral Direct
completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death oncurred at the time, date and place, and due to the cause (s) and manner as stated Poms 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOSPITAL State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #31 per DyRate of Mary and Department of Health and Mental Hygiene 23507 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** /Medical ounty of Death ne (If not institution Examiner Da. RATEY Date of Birth (Month, Day, Year Birthplace (State or Foreign Hrs Min. **Funeral** Days 1 ☐ M 2 🔽 F 56-7651 Director 7-10 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No bal 10e. Street and Number 10g, Citizen of What Country? 21133 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify 3 Widowed 4 Divorced lack Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. PO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ome maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ 19a. Informant's Name/Relationship (Type. Print) Hope wood 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 □Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 100 23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause in eac Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence) f): Examiner Sequentially list conditions, if any, leading to infine late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed for use as the burial-transi and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent gregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed' 1∐ Yes 2 1 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2[] No Other: 4 Mursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural (Month, Day Year) 5 Pending investigation death. 1 🗌 Yes 2 🗌 No the f 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 ☐ Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and a fress of person who completed cause of death (Item-23a) (Type, Print) 2835 ShOTH

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month; Day,

Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Joseph Franklin Shores July 2010 10:30 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital <u>Takoma Park</u> Montgomery 8. Date of Birth
(Month, Day, Year)
July 7, 1950 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours Washington, D. C. 216-60-0593 **Director** Yrs 60 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4701 Coachman Drive 20852 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ò 1X Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Montgomery County of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Groundskeeper Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franklin B. Shores Joan Kirchner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra R. Shores / Sister Eastern Circle, Middletown, Maryland 21769 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Montgomery Crematorium, Inc. July 22, 2010 Bethesda, Maryland 21. Signature of Funeral Service Licensee 22, Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, M01360 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that is interest or impury Examine attending physician and for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death been signed by the a should be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl autopsy 1 Yes 2 No Yes 2 X No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral is 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 2 🗆 No 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certif 29d. Date signed (Month, Pay, Year) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Padma Chirumamilla,

282010

31. Date filed (Month, Day, Year,

32. Registrar's Signature

M.D. 7600 Carroll Avenue, Takoma Park, Maryland 20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh g906 8-24-10 vt State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Reg. No2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ TULY 2 Day 6.51A 2010 Wentz Stewart Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BARMORE WARHINGTON MEDICAL BURNIE ME ARUNISE EH 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 05/onth, Day, Year) 1 □ M 2 🛣 F Months Days Hours Min. 85 **Director** 218-16-1466 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1 Yes No MD Anne Arundel Glen Burnie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 201 N. Crain Highway Apt. 2L 21061 permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: White 3X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Assembler Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည <u>Michaelowski</u> Pauline Zandarski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnold, MD 21012 Pauline Shearer / Daughter <u> 255 Claremont Court</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 07/28/2010 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician NIE FAILURE FENAT disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner TIS Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): bunial-transit and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? ρ Month Year Pregnant at time of death detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death2 Š the funeral director, page 2 should be 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 ☐ Yes 2 ☐ No Yes Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 2 1 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Man of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending ☐ Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) title of certifie 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 27 2010 Name and address of person who cause of death (Item 23a) (Type, Print) Currie MD 21061 aku Registrar's Sign 32

Registrar

STROATET

1 - For State Registrar 23510 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Linda Ann SOLOMON Physician/ July 26 10:28 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 - M 2 X F Days June Months Hours Min. Day 9 946 Washington, DC 64 Director 217-44-5464 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? and Mental Hygiene.
'is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be a Funeral 110 Chevy Chase Street #101 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2X No Black, White, etc. ģ 1 Never Married 2 X Married Specify: white If Yes, Give Year or Dates 1 Yes 2 X No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If Item 27 is marked any linjury or other traumatic ev once. ည Rachel Miller Julian Cohen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Chevy Chase St., #101, Gaithersburg, MD 20878 Albert Solomon, Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, Judean Memorial Gardens 07/28/2010 Olney, MD 21. Si parte e o Funera vice Licensee Torchinsky Hebrew Funeral Home 254 Carroll St., NW. Washington, DC 20012 23a. Part — Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ piration termina Medical resulting in death) Du to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine sician and burial-transit that the death certificate be executed Vomitina that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown s been signed by the a 1 ☐ Yes ∠ ¥ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural injury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🕊 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d, Date signed (Month, Day, Year) D62553 14/4,26,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville MD 20150 Patsy mcNeil 9901 Medical 31. Date filed (Month, Day; Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 23511 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 25^{Day} Physician/ July 2010 6:58 P M Stutz Claire A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A Roland Park Place Healthcare Center Baltimore 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days Months Hours 83 10713/1926 New York, NY 075-24-6362 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore City 1 X Yes 2 No Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21211 830 W. 40th Street 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: "natural", Specify: White 3 🗌 Widowed 4 🗌 Divorced Year or Dates traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Anna Murray Edward Anthony Arnold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 830 W. 40th Street, Baltimore, MD 21211 Robert L. Stutz/ husband permit, Page 1 and 2 Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 07/27/2010 Towson, Maryland Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Towson, MD 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician. Dementia disease or condition resulting in death) Medical Due to (or as a consequence of): ltiple **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examir therosclerosis or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death ed by the a detached f 9 Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown Division of Vital Records, P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? γq Chronic obstructive 1) isee 1 Ses 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to Be 25. Was case referred to medical 26. Place of Death_(Check only one) examiner? 2 🗹 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

State Registrar N. Charles St.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Reg

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	tate of Marylan		irtment of H tificate of D		nentai Hy	giene _{Reg. N} .2 (010	23512
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
	Medic	al	Marcella H. Tibe 4a. Facility Name (if not institution, give street		-	4b. City, Town, or	Location of Death	July 2		nty of Death	11:18A M
,,,,,	Examin	er	Gilchrist	and name on		Towson	Location of Death			Ralto.	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th	9 Rirth	place (State or Foreign
	Director		212-10-4344 Usual Residence of Decedent	91	Yrs.			Decembe:	r 3,191	18 Mar	yland
	f show	tor	10a. State 10b. County	10c. City	, Town or Loc	ation			-		10d. Inside City Limits
	Mary 28a-i notifie	Director	Md. Bal	to.	Notti	ngham_					1 🗆 Yes 2x No
	with the	ral		t.202		2123	6		10g. Citizen	USA	ntry?
	leath v items er mu	Funeral	11. Marital Status 12. V	Vas Decedent Ever in U.S	. 13. V	/as Decedent of His Yes, specify Cubar		ecify Yes or No-	14. F	Race - Americ	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married	Yes 2 X No f Yes, Give 'ear or Dates.		Yes 2 No	Specify:	nicari, etc.)	Spec	Black, White, cify: Whi	
5-0	72 hou "natu edica	Completed	15. Decedent's Educati (Specify only highest grade co	on <i>mpl</i> eted)	(Give k	ent's Usual Occupa ind of work done di		ing	16b, Kind of	f Business In	dustry
7	vithin in interest.		Elementary/Seconday (0-12)	college (1-4 or 5+)		NOT use retired) Iairdress	er		Hair	Care	
g	filed val Hyg	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Surna	ame)	
yla	uld be I Ment narke natic e	욘	Frank Updegraff					Anderson			
⊠	2 sho Ith and 27 is r traun	19	19a. Informant's Name/Relationship (Type, P Joseph Tiberi	rint) Son	1	g Address (Street a. 141 Glen a					
Je,	1 and 2 soft Health item 27 other tra		20a. Method of Disposition	20b. P	lace of Dispos	sition (Name of eatory or other place		Date		on - City or To	
<u>E</u>	Page ment c		1 ☐ Burial 2 🛣 Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	Bay	view	atory or other place	7-27-	-2010	Balto.	Md	
Ball	permit Depart Impor any in	j	21. Sig aure of Funeral Service Licensee	RineRe		Name and Address					
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one call	use on each line.	. Do not ente	r the mode of dying	, such as cardiac o				Approximate Interval Between
	Ph_sician/ Medical	8	Immediate Cause (Final disease or condition resulting in death)	HE-MORRA Due to (or as a consequ	AGIC	STRO	KÉ				Onset and Death DAYS
Separate Sep	Examiner			Due to (or as a consequ	en conf):						
		iner	Sequentially list conditions, b. — if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):						
	ecuted and transi	Examiner	Cause (Disease or linjury that initiated events c resulting in death) Last	Due to (or as a consequ	ence of						
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3760	ificate ig phy as the		IE EEMALE:								
89 ×	th cert ttendir or use	Physician/M	in the past 12 months?	f yes, outcome of pregnar Live Birth 2 — Feta	Ideath 3 🗀	Ectopic pregnancy	/			Date of deliv	rery Day Year
P.O. Box	ne deai the at	ysic	1 Ves 2 No	Pregnant at time of d	eath 5∟	Other (specify)				WIGHT	Day Teal
P.0	that the ned by details		Part II. Other significant conditions contribu	uting to death but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use co	ontribute to the	he cause of death?
ds,	quires en sig ould b	ted I	PRIOR & LIOMA			<u> </u>		1 🗆	Yes 2 No	3 □ Pro	bably 4 🔀 Unknown
Ö	law re has be ie 2 sh	Completed by	PRIOR & LIOMA					24a. Was autop			ppsy findings available empletion of cause of
E E	sician: The law r certificate has k irector, page 2 s		25. Was case referred to medical			26 Pla	ce of Death (Check	1 🗌 Yes	2 X No.	1 Yes	2 🗆 No
Vita Vita	nding Physician: T th. : After this certifica ? funeral director, p	To Be	examiner? 1 ☐ Yes 2 🔀 No	tal: 1 ☐ Inpatient 2 ☐	ER/Outpatien	Othe			dence 6 🕱 C	Other (Specify	HOSPICE
10	ing Ph		27. Manner of Death 1 A Natural 5 Pending	8a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work?	at	28d. Describe h			
Sior	Attend death ctor: A y the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	Be. Place of Injury - At ho	me. farm. stre		res 2 □ No	28f Location (5	Street and Nur	mber or Rura	l Route Number,
Division of Vital Records,	tal or / s after al Dire ed in b		4 Homicide determined	building, etc. (Specify)		,,,	ļ	City or Tow		noor or marca	, include in the state of the s
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifying Physician 2 Medical Examiner: C	n the basis of examination	and/or invest	gation, in my opinior	n, death occurred at	the time, date a	and place, and	due to the ca	use(s) and manner stated.
	Fo the within 2 Fo the comple	Š	only one) 3 ☐ Certifying Nurse Pra 29b. Signature and title of certifier	ctioner: To the best of my	knowledge, d	eath occurred at the 29c. License		e, and due to th	e cause(s) and 29d. Date sig		
	->-0		1000	1)/~		DO	4395		July		
	10 V		30. Name and address of person who comple	eted cause of death (Item	23a) (Type, P	rint)		11 ==			
	Stat		DAN I ELLÉ DOBERNA 31. Date filed (Month, Day Year) JUL 28201	N M Q 670	IN CH	ARUS ST	, 84178 4	1105 €	DHLIII	ione,	MO 21204
	Registra	ar	JUL 28201	Deneur	1. 1	parke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 23513 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 24, Day 2010 Year Physician/ July THERESA FLECKENSTEIN UNKELBACH 1:19A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore 835 Thimbleberry Road Baltimore 5. Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ м аху Months Days Hours Min. 0990271925 219-22-9810 84 Maryland Director Usual Residence of Decedent 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 XXNo Maryland Baltimore Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 835 Thimbleberry Road USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian, Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates Specify: 3€ Widowed 4 □ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item Z7 is marked any injury or other traumatic ev ence. 0 Adam Frederick Fleckenstein Theresa Elizabeth Fitzgerald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Ann Herold DTR 835 Thimbleberry Road Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) ☐ Donation 5 ☐ Other (Specify) 07/29/20**1**0 New Cathedral Cemetery Baltimore, Maryland ^{22. Name and Address of Facility} Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one dions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Onset and Death netastatic Immediate Cause (Final Breast Cancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Examiner if any, leading to immediate cause. Emer Onderlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months
1 Yes 2 No Pregnant at time of death ed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 PNo 3 Probably 4 Unknown cate has been signated by page 2 should b 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? After this certificate 1 Yes 2 No Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 H No ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifie ECertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

thin 24 hours af the Funeral Di mpleted filled in within 2 To the I

State

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only o

Signati

Registrar DHMH 17 Rev 7/2009 oleted cause of death (Item 23a) (Type, Print)
9114 Philadelphia Road #208

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

£ 4539

29d, Date signed (Month, Day, Year) 27th 2010

Baltimore, NO 21237

29c. License number

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#6perFH, G906, 8/2/2010, WS
State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death o Honth Physician/ 2 Tay 2010 9:30A Margaret Wyatt Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A 4025 Frederick Ave. Apt305 Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 04/10/1928 Virginia Director 220-22-3812 82 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Yes 2 No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4025 Frederick Ave. Apt305 U.S.A. 21229 ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: d Mental Hygiene. marked other than "natural", If Yes, Give Specify: Black 3 X Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5th Grade Home Maker Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Fred Shepard Mary Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lula Fletcher(daughter) 4209 Frederick Ave., Baltimore, MD 21229 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Ferenation 3 Removal from State Joseph Brown F7 H 07/28/10 4 Donation 5 Other (Specify) Baltimore, MD Signature of Funeral Service Licenses Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 lamo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician und cancer disease or condition resulting in death) Mears) Medical Due to (s a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of) neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Yes 2 No 1 Yes 2 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 res 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 은 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 7850, 7010 CW D0065249 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Robert Dandson MD

8 2010

31. Date filed (Month, Day, Year,

301 St Poul Place

32. Registrar's Signature

Pite 804

Baltmore, MD

21202

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend Item#10c, perFH, 6905,7/28/2010, WS State of Maryland / Department of Health and Mental Hygiene 0 1 0 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 1:39PM JULY 25 2010 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** AGNES BALTIMDRO Under 1 Year | If Under 24 Hrs. MOSPITAL 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Funeral Days 1 □ M 2 🖫 F Months Hours Yrs. 345-56-6330 Usual Residence of Decedent Director 10c. City, Town or Location **Baltimore** 10d. Inside City Limits 10a. State 10b. County show the Medical Examiner must be notified at 1 Yes 2 No Director MI or 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a USA 21229 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or ite any Injury or other traumatic event, the Medical Examine 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ondon 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be hardson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henr 110.MD21229 20a. Method of Disposition Place of Disposition (Name of 20c. Location - City or Town, State 20b crematory or other place) 1 Burial 2 □ Cremation 3 □Removal from State 105 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FUNEM/ Service 87281 ibert Kuna Kana 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or treat failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPERTENSIVE CARDIOVASCULAR DISEASE YEARS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 □Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) completely filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ATHEROSCUEROTIC CORONARY ARTERY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ es 2 □ No HYPOKALEMIA 24a. Was an autopsy performed' 2□No Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

5

State Registrar 31. Date filed (Month, Day, Year)

JUL 2820

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ATONAVE BALTIMORE, MOZIZZ9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are egible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month 2010 25 July 2:30 A Jane F. Williams Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Hours Sept. 5, Days Min. 1 M 2 X F Illimois 1929 80 Director 498-26-3667 Yrs. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 🏻 Yes 2 🗆 No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20850 14421 Traville Garden Circle, #112C Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Baltimore, Maryland 21215-0036 Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Business Machines Payroll Administrator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Bridget Alward Edwin Fitzsimmons 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 10502 Manor View Place, Manassas, Virginia 20110 David B. Williams / 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State July 30, 2010 Silver Spring, MD Gate of Heaven Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lic Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Ave., Rockville, MD 20850-2805 M00896 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heard failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 weeks Immediate Cause (Final Physician Acute Renal Failure Medical resulting in death) Due to (or as a consequence of) Examiner Congestive Heart Failure 2 years Sequentially list our citions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury ed by the attending physician and detached for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) Yes 2 X No 9 Unknown is certificate has been signed by director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atherosclerotic Cardiovascular Disease 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe After this certificate I 2 **X** No Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28b. Time of 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural 5 Pending 1 🗌 Yes 2 🗆 No М Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

MI GOZOTAM O230AM

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07 25

VILLIAMS

State Registrar

29a. Certifier

(Check

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

Rajvanshi, M.D., 121 Congressional Lane, Rockville, Maryland 20852

2 I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D37891

29d, Date signed (Month, Day, Year)

July 25, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State	of Mary		irtment of F tificate of D	lealth and M Death	•		010	23517
	Physicia		1. Decedent's Name (First, Middle Carroll J. Wal						2. Date of Dea 0 7-24-		Year	3. Time of Death 0900 A M
	Medic Examin		4a. Facility Name (if not institution	n, give street and nu	mber)		4b. City, Town, or Abing	Location of Death		4c. Cou	inty of Death	
	Funeral		305 Tiree Ct 5. Social Security Number 178-22-9715	6. Sex 1 🔀 M 2 □ F	7. Age (In)	vrs. last birthday) 2 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	:h		nplace (State or Foreign ntry)
	Director		Usual Residence of Decedent						04-00-	1720		
	ryland I-f shoried at	ctor	10a. State 10b. County MD Harf		100	a. City, Town or Loc Abin						10d. Inside City Limits 1 ☐ Yes 2X☐ No
	the Ma or 28a e notif	Dire	10e. Street and Number	ora	<u> </u>	AULII	10f. Zip Code			10g. Citizen	of What Cou	
	h with i is 23a nust b	Funeral Director	305 Tiree Ct				21009				SA	
036	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marked other than "dedical Examiner must be notified at	q	 11. Marital Status 1 ☐ Never Married 2 X Mar 3 ☐ Widowed 4 ☐ Divorced 	rried Armed F	edent Ever i orces? 2 X No ive oates.	l1	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto Specify:	city Yes or No- Rican, etc.)		Race - Ameri Black, White, c <i>ify:</i> Whi	, etc.
2-0 -0	72 hour "natu edical	Completed	15. Decede (Specify only high	ent's Education est grade complete	d)	1 (Give I	lent's Usual Occupa kind of work done of NOT use retired)	ation Juring most of worki	ng	16b. Kind o	of Business Ir	ndustry
212	within 7 giene. er thar , the M		Elementary/Seconday (0-12)	College	1-4 or 5+)		Service	Director		Nursi	ng Hom	ne
Maryland 21215-0036	e filed ntal Hyg ed oth event,	To Be	17. Father's Name (First, Middle, Tempest S. Wal		=			18. Mother's Name Phoebe			ame)	
aryle	nould b nd Mer s mark umatic		19a. Informant's Name/Relations		-	19b. Mailir	ig Address (Street a	and Number or Rura			n, State, Zip	Code)
ž,	nd 2 sh ealth a m 27 is ner trai		Mildred I. Wal	tersdorf				Abingdon				
Baltimore,	permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en		20a. Method of Disposition 1 X Burial 2 □ Cremation 4 □ Donation 5 □ Other (Specify)	n State	Lakeview	Cemetery Cemetery	07-28	Date 3,2010	Sykes	on - City or 1	MD
Ba	permit Depar Impor any in		21. Signature of Funeral Service	Licensee Ru	· Kr	22 I	. Name and Addres	^{ss of Facility} Sch MacPhai	imunek L Rd Be	Funera 1 Air,	1 Home MD 21	of BelAir
	Hrysician/ Medical Examiner	80 A	23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on e	each line.		er the mode of dying		or respiratory ar	rest,		Approximate Interval Between Onset and Death
	certificate be executed nding physician and use as the burial-transit	al Examiner	Sequentially list conditions, flat y, Leading to fine oldate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. The conditions of the condition									
1760	icate b g physi as the b	/ledical		d								
Box 68	requires that the death certific been signed by the attending should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e Birth 2 🗀 egnant at tim	Fetal death 3	Ectopic pregnand Other (specify)	ey		23d	. Date of deli Month	ivery Day Year
ds, P.O.	or Attending Physician: The law requires that the death street death. Director: After this certificate has been signed by the atter in by the funeral director, page 2 should be detached for in by the funeral director,	Ş	Part II. Other significant condit	ions contributing to	death but no	ot resulting in the u	inderlying cause giv	ven in Part I.				the cause of death?
Division of Vital Records,	The law ate has page 2	Completed									prior to death?	opsy findings available completion of cause of
/ita	s certifi	To Be	25. Was case referred to medica examiner? 1 Yes 2 No	Hospital:	Inpatient	2 D ER/Outpatier	Oth	ace of Death (Chec er: 4 Nursing Ho		dence 6 🗍	Other (Speci	ifv)
on of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Certificate: T		ing 28a. Dat (Mo	e of injury onth, Day, Yea	28b. Time of	28c, Injur work	y at	28d. Describe			
ivisi	or Atter de Directo		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	minod 28e. Plac	ce of Injury - ding, etc. (Sp	At home, farm, str pecify)	eet, factory, office		28f. Location (City or To		ımber or Rur	ral Route Number,
	ne Hospita n 24 hours ne Funeral	Medical	(Check 2 Medical	ng Physician: To the Examiner: On the b 19 Nurse Practione	asis of exami	nation and/or inves	tigation, in my opinio	on, death occurred a	t the time, date	and place, and	d due to the c	cause(s) and manner stated.
	Vithi Vom		29b. Signature and title of certific	Handar	un		29c. Licens			29d. Date si	gned (Month	n, Day, Year)
	121		30. Name and address of person	who completed ca		(Item 23a) (Type, F	Print)	126318 ver Dni	u. Al	ingden	ma	2009
	Sta Registr		31. Date filed (Month, Day, Year)	32	Registrar's S	Signature	arkel		(l	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2010 HEL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SECOURS BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 9. Birthplace (State or Foreign **Funeral** Days 1 🛛 M 2 🗆 F 10-16-1923 MARYLAND Director 216-12-6885 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Evantics must be notified at 1∏Yes 2☐No Director BALTIMORE MD. N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code IISA 21216 1648 N. SMALLWOOD ST. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No BLACK 2 Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HECHT COMPANY -12--0-TRANSPORTATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be STEVELLA PARKER JOHN WALLACE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1648 N. SMALLWOOD ST. BALTIMORE, MARYLAND 21217 NAOMI WALLACE (WIFE) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3 Removal from State 5 ☐ Other (Specify) GARRISON FOREST VETERANS 8-3-2010 OWINGS MILLS, MARYLAND D. HIBNER 2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. of Funeral Service 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Approximate Interval Between Onset and Death 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immed at Cause (Fi disease or condition resulting in death) CARDIOVASCULAR Cause (Final DERTENSIVE Physician /Medical Du t (or as a consequence of): Examiner OBSTRUCTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed GASTROIN PER and Due to (or as a consequence of): burial-Box 68760, physician Physician/Medical the attending | for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy Day Month Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No P.0. the 9 Unknown 9 Unknown signed by t 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? the Hospital or Attending Physician: The certificate 2 - No 1 🗌 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\Bigcap \) Nursing Home \(5 \Bigcap \) Residence \(6 \Bigcap \) Other (Specify) 1 ☐ Yes 2 ☐ AND 1 ☐ Japatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 - Natural 5 Pending ithin 24 hours after death.

the Funeral Director: After Direc 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 2.

State Registrar

Medical

31. Date filed (Month, Day,

29b. Signature and title of certifier

29a. Certifier

(Check only one)

32. Registrar's Signature

and manner stated.

30. Name, and address of person who completed cause of death (Item 23a) (The, Print)

ORIGINAL

1 < - ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

BON SECOURS

29d. Date signed (Month, Day, Year)

10-05510 James B. Young

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2010 23519 State of Maryland / Department of Health and Mental Hygiene

		For State Certificate of De	eath	Re	g. No.				
Physicia	_	1. Decedent's Name (First, Middle,Last)		2. Date of Deat Month	n Day Year	3. Time of Death			
ীical Examin	er	James B. Young , Jr.		July 23, 20	110	1551 hrs			
		Tac. I denty realis (i not institution, give a see a see	City, Town, or Location of D	eath	4c. County of D				
	н	Baltimore Washington Medical Center G	Blen Burnie		Anne Aruno				
Funeral	╗	5. Social Security Number	f Under 1 Year If Under 24 Months Days Hours		5,1966	Birthplace (State or preign CountMaryland			
Director	1	216-82-3253 1XM 2F 44 Yrs.	5-82-3253 1XM 2FF 44 Yrs. Months Days Hours Min						
	ŀ	Usual Residence of Decedent				40d Incide City Limite			
any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits			
nd show	닐	MD. Anne Arundel Severn				1 Yes 2 No			
Maryland 28a-f show any datonce.	둟	10e. Street and Number	Of. Zip Code	10	g. Citizen of What	Country?			
the M	Director	1321 Sleepy Hollow Road	21144	υ	nited Sta	ites			
5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	曺	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was De	ecedent of Hispanic Origin? specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - A White, et	merican Indian, Black,			
leath r iten	Funeral	1 Never Married 2 Married Armed Forces? If Yes, s	specify Cubari, Mexican, Fo	lerto Modri, etc.)		White			
ifter of II", o		3 Widowed 4 XDivorced If Yes, Give Year 1 Ye	s 2 X No specify:		Specify:				
ours a	딁		Usual Occupation (Give kind of working life. DO NOT use		16b. Kind of Busine	ess/Industry			
72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	· ·		L				
orthin ene.	티	12 N/A Disable	Lionen	lame (First, Middle, M	Disable				
215-0036 be filed within ntal Hygiene. -ked other tha ent, the Medic		17. Father's Name (First, Middle, Last)							
2121 uld be fil Mental F marked c event, p	_	James B. Young, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ad	SYIV18	E. West		State Zip Code)			
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic event, the Medica	2		eepy Hollow F						
C 42 72 12 12 12 12 12 12 12 12 12 12 12 12 12	_	20a Mathad of Disposition 20h Place of Disposition	n (Name of cemetery.	Date	20c. Location - Cit				
ore,	М	1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	place) Memorial Ji	11v28,2010	Glen Burn	nie,Maryland			
Page Page nent ant:		The state of the s							
Baltimore, permit. Pages 1 a Department of He Important: If ite	-11	AMBR	ne and Address of Facility OSE FUNERAL I Hammonds fea	HOME OF LA	NSDOWNE ,	m 01007			
E. E. G. B. CE.	1					4D. 21227 Approximate Interval			
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the n failure. List only one cause on each line.	node or dying, such as card	lac of respiratory an	est, shook, or flour	Between Onset and Death			
/Medical Examiner	- 1	Immediate Cause (Final disease a. Methadone Intoxication				Death			
McG		or condition resulting in death) Due to (or as a consequence of):							
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
	틢	cause. Enter Underlying Cause				_			
	Examiner	events resulting in death) Last Due to (or as a consequence of):							
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Box 68760, e death certificate be the attending physic ed for use as the bur		IF FEMALE. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal	death 3 Ectopic pr	regnancy	23d. Date of de Month	Day Year			
ox 687 cath certificate attending for use as t	Physician	past 12 months?	· (Specify)	-g,					
SOX death	Şi	1 Yes 2 No 9 Unknown 9 Unknown							
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ds, requir	eţe			24a. Was auto	an 24b, We	re autopsy findings available or to completion of cause of			
COC law law e 2 sh	ם				rmed? dea				
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ital ician s cert recto	a	examiner? Hospital: 1 Innation: 2 FR/Outpatient 3	1Othor: F		Residence 6	Other:			
Phys Prys er thi	£	27. Manner of Death 28a. Date of Injury 28b. Time of Injury		28d. Describe	how injury occurred				
oding h : Aff	<u>.</u>	1 Natural 5 Pending (Month, Day, Year)	1 Yes 2 N	ю					
SiO Atter r dear ector by th	cat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, 1	factory, office building, etc.	28f. Location (Street and Number	or Rural Route Number, City			
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the sa dree death. "al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach.	Certification:	Suicide Could not be determined (Specify)		or Town,	State)				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		29a. Certifier 1 Certifying Physician: To the best of my knowledge death occurred	d at the time, date and place	e, and due to the cau	se(s) and manner a	s stated.			
the H	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation	n, in my opinion, death occu	rred at the time, date	and place, and due	e to the cause(s)			
To wit	Me	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed	(Month, Day, Year)			
		Mourant to all 10	O.C.M.E.		July 24, 2010	0			
		30. Name and address of person who completed cause of death (Item 23a)							
$\langle \gamma \rangle$			nn Street, Baltimore,	MD 21201					
S	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature							
Regist		1111 00 0010 6 6	Kel						
DHMH 17 Rev 1/2	001	ORIGINAL				Octor			

Jeanett 21215-0036 Zimmerman. Maryland Baltimore,

amend #16ashateer Margia RD / Contificate of Death

Reg. No. 2010 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** JULY Jeannette Eileen Zimmerman 22 2010 /Medical . Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner timore Square Hospita Franklin seda 0 If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb 9, 1934 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Mary Land Months Days Hours Min. 1 □ M 2 🗓 F 76 219-28-1641 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Modical Examinar most be notified at Director 1 ☐ Yes 2X No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 USA 2C Dunsinaine Dr. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: Specify: White Completed by 3 ☐ Widowed 4 € Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupati 16b. Kind of Business/Indust (Give kind of work done during most of working life. DO NOT use retired) Home Selling Assistance College (1-4or 5+) Elementary/Secondary (0-12) Realty Group 12 **Realtor** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sorothy Irene White Charles Ellis Garrity 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health ar Victoria Little - daughter 1636 Castleton Road; Darlington, Maryland 21034 item 27 other to 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages ţ, permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Struct Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca (Final disease or condition resulting in death) **Physician** a Metastasis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, for your cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consectionne of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-tra resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 C Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No 1. Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 33 7/22/10 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ahmed 9000 Franklin Sovare Drive Baltimore Mb. 21237 Dr. Hirmans 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BETTY July R 2010 AUTON 9 11:24 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 10911 Fingerboard Rd. Monrovia Frederick Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🖔 F FEB. 5, Year 31 Months Days Hours Min. **Director** 546-40-3738 California Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits Maryland Frederick Monrovia 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10911 Fingerboard Rd. 21770 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 Never Married 2 Married Black White etc. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: 3 X Widowed 4 Divorced White d Mental Hygiene. marked other than "natur matic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Warren Sealight injury or other traumatic Eunice Ryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Smith / daughter 4182 Windy Hill Dr./ Monrovia, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of F
Important: If ite
any injury or ot Date 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State 7/13/2010 Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown pike/ Frederick, MD 21702 23a. Part Valer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, r heart failure. List only one cause on each line. Immedi W Cause (Final Rheumatail Physician/ Onset and Death disease or condition resulting in death) 46946 Medical Due to (or as a consequence of): **E**xaminer Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury Examine Due to (or as a consequence of) and -transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Pregnant at time of death Other (specify) Month Day Year g Unknown P.O. | s been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires t Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate i performed' Yes 1 Yes 2 No 2 📝 No filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 III No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 2 Accident Investigation 1 Tes 2 🗌 No ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 only one) 254283 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5093 Ragarished Dive Flodorich mi OI iarkowski 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Division of Vital

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	For State Registrar	Plea	se Type or I State of		d / Depa		Health and I	Mental Hy	niene	gible.		
Physician/ Medical	1. Decedent's Na	FREDER	CK ANDREW					2. Date of Dea	ath	3. Time of Death 8:00 PM		
Examiner		A HILLS	nursing H	OME		4b. City, Town, or CENTREV If Under 1 Year	LLE If Under 24 Hrs.	8. Date of Birt		ANNE'S		
Funeral Director	219–18– Usual Residence	5670	6. Sex 7	7. Age (In yrs. Ia 84	Yrs.	Months Days Hours Min. (Month,			Y Year) 2, 1925	9. Birthplace (State or Foreign Country) MARYLAND		
Maryland 28a-f shov otified at rector	10a. State MARYLAND	10b. County	ARUNDEL	JNDEL ANNAPOLIS						10d. Inside City Limits 1 ☐ Yes 2 X No		
leath with the Maryland tems 23a or 28a-f sho er must be notified at Funeral Director	10e. Street and N	umber					10f. Zip Code 21401			What Country?		
ter or in amin		arried 2	Armed Ford ed 1 Tyes 2 If Yes, Give	Armed Forces?			Was Decedent of Hispanic Origin? (Specify Yes or Not f Yes, specify Cuban, Mexican, Puerto Rican, etc.) □ Yes 2 No Specify:			ce - American Indian, ck, White, etc. ***********************************		
within 72 hours ar jiene. er than "natural" the Medical Ex			t's Education st grade completed) College (1-4	l or 5+)	(Give F life. D	lent's Usual Occup kind of work done o O NOT use retired) PENTER	ation duni <i>ng m</i> ost of won	king	16b. Kind of B	susiness Industry JCTION		
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and 2 short Health and In 27 is n	PATRICIA		ip (Type, Print) INSKY/COUS		200 KI	ENT ROAD,	STEVENS		D 21666	5		
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be executed / Nedical / Medical Examiner cal Examiner	23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Approximate Interval Between Onset and Death Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but Medical Certificate: To Be Completed by Physician/Medical	150	hemic Ardii	cardiomy Miffer			nderlying cause giv	ven in Part I.	1 🔲	Yes 2 No an 24b.	tribute to the cause of death? 3 Probably Unknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
I or Attending Physician: after death. Director: After this certifi I in by the funeral director. Certificate: To Be	27. Manner of De Natural 2 Accident	ath 5 Pending	28a. Date of (Month)	npatient 2 f injury f, Day, Year)	ER/Outpatien 28b. Time of injury	t 3 DOA Other	y at	ome 5 Resid	dence 6 Oth			
ital or Atte ins after de al Directo led in by th	3 ☐ Suicide 4 ☐ Homicid		ned 28e. Place o building	g, etc. (Specify)	eet, factory, office		City or Tow	n, State)	per or Rural Route Number,		
To the Hospita within 24 hours To the Funeral completed filled	29a. Certifier (Check only one) 29b. Signature an	2 ☐ Medical Ex 3 ☐ Certifying	Physician: To the best caminer: On the basis Nurse Practioner: To	of examination	n and/or invest	igation, in my opinic	on, death occurred a e time, date and pla	at the time, date a ace, and due to the	nd place, and du e cause(s) and m	ie to the cause(s) and manner stated		
il no	MI	Crow	the completed cause	6/4	De Du	rint)	Lane,	Easto	n, M)	21601		
State Registrar	31. Date filed (Mo	n <i>th, Day, Year)</i> L 12 201	O Seven	gistrar's Signat	park	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 23523 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Anderson 07:58 07 Medical 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Battimore Iniversity of Manyland Medica If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday 1 DM 2 1 Hours 218-70-0273 51 Director צידי 23 Tune Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Upperco 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 5715 Emory Rd. 21155 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed Specify: White 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) h and Mental Hygiene. 7 is marked other than "r traumatic event, the Med Johnsons Bus Śervice Elementary/Seconday (0-12) College (1-4 or 5+) School Bus Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) it. Page 1 and 2 should be file rtment of Health and Mentall rtant; If item 27 is marked on njury or other traumatic eve Barbara L. Brown Thomas C. Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code)
29 Webster St., Westminster, MD 21157 Lucas B. Anderson - Son permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other ti 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Carroll Cremations 7/12/2010 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Freer the disease, or complice shock or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition meumonia Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗆 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2: autopsy performed?

Yes 2 No 1 Yes Ba 25. Was case referred to medical 26. Place of Death (Check only one) examiner? <u>ء</u> 2 No Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year, 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifie 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier $^{29c.\,License\,number}\, ext{ID}\,\,\#100627$ 29d. Date signed (Month, Day, Year) MD 7/10/10 518285519 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Briana

31. Date filed (Month, Day, Year)

Short

JUL 1 3 2010

South

Greene St. Baltimore

MD.

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32 Registrar's Signature

John Franklin Alkinson 10-05195 **UNK UNK**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2010 23524

		1- For State Certifica	te of	Death			Reg. N	No.		
Physiciar	1/	Decedent's Name (First, Middle, Last)				Date of D Month	Death Da	ay Year		3. Time of Death
Medical Examin		John Franklin Atkinson		15 Cit T	al acatin	July 11				1221 hrs
	ı	4a. Facility Name (if not institution, give street and number) Grimville Road		Skyesville				Carroll		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day)	If Under 1 Year Months Day		_			9. Birth Foreign	place (State or Maryland
Director		219–74–0795 1 ⋉ м 2□F 51	-74-0795 1 M 2 F 51 Yrs. Months Days Hours							
Š.	- 1-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	- 1	10d. Inside City Limits						
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Maryland 28a-f show 1 at once,	흸	10e. Street and Number		10f. Zip Code			10g. (Citizen of Wha	at Count	ry?
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5-0 led w Hygie		17. Father's Name (First, Middle, Last)	-			s Name (First, Midd		den Surname)		
121 d be f lental arkec	8	John W. Atkinson	Moiling	Address (Stra		Doris Ore		City or Town	State	Zin Code)
MD 21215-0036 at 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than unantic event, the Medica	٥					ll Road,				
ore, MD 21215-003 is I and 2 should be filed within of Health and Mental Hygiene. If item 27 is marked other the	ŀ	20a. Method of Disposition 20b. Place of	Dispos	ition (Name of ce		Date		Oc. Location -		
nore ages 1 at of F other		1 Burial 2 Cremation 3 Removal from State Source		rer place) Cremator	$_{\rm v}$	7/13/201	0	Winfie	eld,	MD
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2	ŀ	4 Donation 5 Other Specify: Call O. 2) Signature of Funeral Service Licensee	22. N	lame and Addres	s of Facility		urb	oraw Fi	ıner	al_Home
Balt permit. Depart Import	+	Just R. Duebon				et, Westm	iins	ter, M	21	157
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not deliure. List only one cause on each line.	enter th	ne mode of dying	, such as c	ardiac or respiratory	arrest,	shock, or hea	rt	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease a. Shotgun Wound of Neck and	Head							Death
	- 1	or condition resulting in death) Due to (or as a consequence of):								
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68760, certif-cate be executed noting physician and se he bunal - transit		IF FEMALE: 23c. If yes, outcome of pregnancy						23d. Date of		
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Sior Attend death death sctor:	<u>`</u>	2 Accident Investigation Jul 11, 2010 1221	hrs				n /Stre	et and Numbe	er or Rus	ral Route Number, City
Division of Vital Records, P.O. ral or Attending Physician: The law requires that it rs after death. Tal Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	ertification:	3 Suicide 6 Could not be determined (specify) Woods	m, sue	et, ractory, office	building, et	or Tow	n State	e)		RD, Sykesville, MD
hou hou	ပြု	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, deal				ace, and due to the	cause(s) and manner	as state	d.
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	Ž	29b. Signature and title of certifier			se number	OCME		9d. Date signe		ith, Day, Year)
MIL		Theodore M. King Thyme.)	0.0	.M.E.		J	July 12, 20	10	
2		30. Name and address of person who completed fluse of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Exami	ner	111 Penn S	treet, Ba	ltimore, MD 21	201			
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature								
Registr	ar	JUL 1 4 2010 Jenus B.	40	Kel						
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DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Adams 2504M 2010 5 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Washin usdown ta recessor If Under Vear | If Under 24 Hrs 8. Date of Birth (Month, Day, june 20, Birthplace (State or Foreign Country) **Funeral** 1 **X**M 2 □ F Months Days Hours 90 Pennsylvania Director 143-18-9738 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at 10d Inside City Limits Funeral Director 1 ☐Yes 2 X No Hagerstown MD Washington 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be 1 21742 USA 14014 Marsh Pike 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Army 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 XYes 2 No Arm If Yes, Give 44-46 Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify: Completed by 3 XiVidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frew Bertha ပ Earl Adams Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Leanne M</u>. Neveil / Daughter 1556 Park Terrace Dr., Chambersburg, PA 17202 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Smithsburg Crematory 07/16/2010 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 5, 305 N. Potomac St., Hagerstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician rementa disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy 2**/** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 2 TER/Outpatient Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No s after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

2

State Registrar 29b. Signature and title of certifier

Dav. Year)

15

31. Date filed (Month)

DHMH 17 Rev 1/2001

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Marsh Dike Heyerstown MD 21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 23526 State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 20ÎÖ Michael E. Bover 3:45 р. м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4642 Jefferson Pike Frederick Jefferson 9. Birthplace (State or Foreign Country) Maryland Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 ▼ M 2 □ F Months Days Hours Min. December 12" Director 220-42-5658 66 Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f shorex aminer must be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Jefferson Maryland Frederick 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4642 Jefferson Pike 21755 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Elementary/Seconday (0-12) 12 life. DO NOT use retired) College (1-4 or 5+) Self-Employed Draftsman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Herschel T. Boyer, Sr. Mary A. Thrasher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcia Jane Boyer / Wife 4642 Jefferson Pike, Jefferson, Maryland 21755 or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Paul's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Jefferson, Maryland of Funeral Service Lice Keeney and Basiord PA Funeral Home, MO1473 106 E. Church Street, Frederick, Maryland 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ met astatic prostate disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy hours after death.

neral Director. After this certificate has been signed by the atter
of filled in by the funeral director, page 2 should be detached for u in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Certificate: To Be Completed 1 ☐ Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a, Was an autopsy performed? Yes 2 N prior to completion of cause of death? 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 PNo Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ♣ Residence 6 ☐ Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 2 Natural injury work? 1 ☐ Yes 2 ☐ No. Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a
To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) ignature and title of certifie 29c. License number mn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Usclo 32. Registr 31. Date filed (Month, Day, Year) r's Sian

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are 2 blie 2 3 5 2 7 State of Maryland / Department of Health and Mental Hygiene

		-	State Registrar		Cer	tificate of L	Death		Reg. No.			
I	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death	
	Medic		Annette Louise	Brown				July	7	2010	9:40a M	_
	Examin		4a. Facility Name (if not institution, give s	treet and number)		•	Location of Death		4c. C	ounty of Death		
			298 Pinoak Drive 5. Social Security Number 6. Sex	7. Age (In yrs. las	st hirthday)	If Under 1 Year	ederick If Under 24 Hrs.	8. Date of Bir	th	Frede	rick place (State or Foreign	_
	Funeral Director			M 2X F 61	Yrs.	Months Days	Hours Min.	JAN 6	y Year) 1949	Mary	try) Land	
	*		Usual Residence of Decedent									_
	yland f sho sd at	tor	10a. State 10b. County		Town or Loc					1	Od. Inside City Limits	
	Many 28a- potifie	Director	Maryland Frederi	ck Fr	ederi						1X Yes 2 □ No	_
	th the	alD	10e. Street and Number 298 Pinoak	D		10f. Zip Code	1701		J	en of What Cour	·	
	ms 2 musi	Funeral		Dr. 12. Was Decedent Ever in U.S.	12.14	Vas Decedent of H	1701	ecify Ves or No-		ted State 4. Race - Americ		_
_	or ite	by Fi	11. Marital Status 1 ☐ Never Married 2 XX Married	Armed Forces?	If	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	1 '-	Black, White,		
3	rsaft iral", Exar	edk	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.	1	Yes 2X No	Specify:		Sp	pe <i>cify:</i> B1	Lack	
9500-61212	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad			ent's Usual Occup		kina	16b. Kind	d of Business Inc	dustry	
7	hin 73 ne. than	E	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DC	O NOT use retired)			T		0	
N	Hygie Hygie ther ont, th	Be C	17. Father's Name (First, Middle, Last)		Nati	ng Clerk	18. Mother's Nan	ne (Eirst Middle		urance (Lompany	-
Maryland	be file	일	Augustus	Pa1m			Bernic		Kir			
$\mathbf{\bar{z}}$	ould Me mari		19a, Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street a					Code)	-
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<u>6</u>	1 and of Hei item		20a. Method of Disposition		ace of Dispos	sition (Name of natory or other place		Date		ation - City or To	own, State	_
Ē	Page nent d ant: If		1 X Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)	icinioval nom otate		h Cem.		3,2010	 Knox	ville,	Maryland	
saitimore,	permit. Page 1 s Department of H Important: If ite any injury or ot		21. Si pri re of Funeral Service License	e - 01		. Name and Addres	ss of Facility Sta	auffer 1	Funera	al Home	•	Ī
n	997 = 29		sherrow Earn	ulle Toll		21 Oposs				k, MD 2	21702	
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only one	ications that caused the death e cause on each line.	. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between	
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	ed sit	Examiner	cause. Enter Underlying Cause (Disease or linjury	Date to for an a conseque	5.1.00 0.7.							
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٥ ×	tendii r use	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnar 1 D Live Birth 2 D Fetal	death 3	Ectopic pregnanc	¢у		23	3d. Date of delive Month	ery Day Year	
X Q Q	deat the at	Physician,	1 Yes 2 No	4 ☐ Pregnant at time of dog ☐ Unknown	eath 5∟	Other (specify)				Month	Day 10ai	
л Э	at the	/ Ph	Part II. Other significant conditions con	ntributing to death but not resu	ılting in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco use	contribute to the	he cause of death?	
Š,	signe d be	d by						1 🗆	Yes 2X	No 3 □ Pro	bably 4 🗆 Unknown	
ecords,	requ	lete						24a. Was	an	24b. Were auto	psy findings available	-
ပ္ပို	ne law e has age 2	Completed		<u>.</u>				auto	psy ormed? 2X No	prior to co death? 1 ☐ Yes	mpletion of cause of	
工 悪	an: The tifficat for, pa	Φ	25. Was case referred to medical			26. PI	ace of Death (Chec		2.0 No	i □ res	2 L NO	
Ĭ	ysicis is cer direct	To B	examiner? 1 ☐ Yes 2 🗶 No	lospital: 1	ER/Outpatien	nt 3 □ DOA Oth	er: 4 🗌 Nursing H	ome 5 X Resi	dence 6	Other (Specify	()	
0	ng Ph fer th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury	y at	28d. Describe	how injury c	occurred		
<u>o</u>	tendii leath. or: Ai the fu	ifica	2 Accident Investigation 3 Suicide 6 Could not be			M 1□	Yes 2 No				35	_
DIVISION OT VITAI K	or Att	Certificate:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre	eet, factory, office		28f. Location (City or To		Number or Rura	I Route Number,	
בֿ	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a, Certifier 1 X Certifying Physi	cian: To the best of my knowle	edge, death o	occured at the time	date and place a	nd due to the co	ause(s) and	manner as state	ed.	_
	e Hos 124 h Fun e Fun	Medical	(Check 2 Medical Examin	er: On the basis of examination e Practioner: To the best of my	and/or invest	igation, in my opinio	on, death occurred	at the time, date	and place, a	and due to the ca	use(s) and manner stated	i.
	To the within To the comp	2	29b. Signature and title of certifier			29c. License			29d. Date	signed (Month,	Day, Year)	_
			•	e MY	/	D 6	7931		07	7/09/	12010	
			30. Name and address of person who co									
	7		Sebastien Kairo			s Johnson	Dr./ Fr	ederick	, Mar	yland 2	1702	_
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure	hor Kal						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) $\overset{\text{Month}}{Julv}$ Physician/ Mark Burton Lee 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1701 Brannocks Neck Road Cambridge Dorchester 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** Days Maryland Hours June 16. 1 ★ M 2 □ F 212-66-2474 55 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 72 hours after death with the Maryland Director MD Dorchester Cambridge 1 Yes 2 K No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 1701 Brannocks Neck Road 21613 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) owner/operator trenching company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Julian Burton Dorothy Gooch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheri Burton wife 1701 Brannocks Neck Rd., Cambridge, MD 21613 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Old Trinity Churchyard 1 X Burial 2 Cremation 3 Removal from State 7/16/10 Church Creek, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. Signature/pf Funeral Service Licensee 700 Locust St., Cambridge, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Immediate Cause (Final Physician/ months disease or condition resulting in death) Medical Due to (or as a conseq. ence of) Examiner Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Year Day Pregnant at time of death Yes 2 No the g Unknown Division of Vital Records, P.O. þ use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacc icate has been signed it; page 2 should be det þ 3 Probably 4 Unknown 2 No Completed 24b. Were autopsy findings available 24a Was an autopsy performed prior to completion of cause of certificate I 1 Yes 2 No Yes 2 🐷 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to me 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner Leath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Matural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Destifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

30. Name and address of person into completed cause of death (Item 23a) (Type, Print)
Mary Ann Moore, M.D. 300 Dorchester Ave., Cambridge, MD

32 Registrar's Signature

21613

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State of Maryland / [State Registrar	Department of Hea Certificate of Dea	alth and Men <i>ath</i>	tal Hygier Reg.	2010	23529	
	Physicia	n/	Decedent's Name (First, Middle, Last) Myrtle Virginia BRADFORD			Date of Death		3. Time of Death	
	Medic	al	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Loc	cation of Death	viy i	4c. County of Dea	ath	
) Examin		Washington County Hospital	Hagersto	own	Washington			
I	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 🖾 F 7. Age (In yrs. last birt 85		Hours Min. 8. D	Date of Birth Month, Day, Yea pt. 19, 1	9. Birthplace (State or Foreign Country) Virginia		
	how at	'n	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits	
	Marylar 28a-f s atified	recto	Maryland Washington Hage	rstown				1 🔀 Yes 2 🗆 No	
	ith the 23a or 3 st be no	Funeral Director	10e. Street and Number 224 Pangborn Boulevard	10f. Zip Code 21740			. Citizen of What C JSA	Country?	
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "Inatural", or items 23a or 28a-f show other tranmatic event, the Medical Examiner must be notified at		11. Marital Status 1 □ Never Married 2 🄀 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give	13. Was Decedent of Hispa If Yes, specify Cuban, N	Mexican, Puerto Ricar	Yes or No- n, etc.)	14. Race - Am Black, Wh Specify: W		
2-00	hours 'natura' dical E	olete	Total of Bates.	Decedent's Usual Occupatio (Give kind of work done during	on na most of workina	16b	o. Kind of Busines	s Industry	
121	ithin 72 ene. r than ' the Me	Completed by	Flamonton (Connector (0.10) College (1.4 or Ft)	life. DO NOT use retired) ousewife	ng most er tremmig		her own	home	
Baltimore, Maryland 21215-0036	I be filed w fental Hygi rked othe tic event, I	To Be	17. Father's Name (First, Middle, Last) Daniel Pyne	18	3. Mother's Name (Firs Ada Tho		len Surname)		
, Mary	id 2 should salth and M n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Harvey Bradford - husband 2	. Mailing Address (Street and 24 Pangborn Bo	Number or Rural Rou oulevard,	ute Number, City Hagerst	or Town, State, 2	Zip Code) • 21740	
imore,	permit, Page 1 an Department of He Important: If iten any injury or otho		4 X Duriel Commention Commenter Camera	f Disposition (Name of ry, crematory or other place) Haven Cemeter	Date y 7/16/10		agerstow	or Town, State	
Balti	permit, Departr Importa any inju	1 3	21. Signature of Fun ral Service Licensee	22. Name and Address of 415 E. Wils			NERAL HON		
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.				0 ()	Approximate Interval Between Onset and Death	
	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence	TE MYOU	ARDIAL	INFA	RCTION		
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	icate be executed physician and is the burial-transit	dical Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence.	eumonia					
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Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	n 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of o	delivery Day Year	
s, P.O.	requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given	in Part I.			to the cause of death? Probably 4 🗆 Unknown	
Record	he law requite has beer age 2 shou	Completed				24a. Was an autopsy performed 1 Yes 2	prior to	autopsy findings available o completion of cause of ? //es 2 \(\sum \) No	
tal	ician: T sertifica ector, p	Be	25. Was case referred to medical examiner?	Othor:	e of Death (Check only	y one)			
of Vi	g Physical this derail direction	e: To	1 Yes 24 No 1 Inpatient 2 L ER/O 27. Manner of Death 28a. Date of injury 28b.	utpatient 3 □ DOA □ Time of 28c. Injury at	4 ☐ Nursing Home t 28d.	5 Residence Describe how in		ecify)	
on	tending leath. or: Aft the fun	Certificate:	Natural 5 Pending 2 Accident Investigation	M 1 ☐ Yes	s 2 🗆 No				
Divis	al or At s after of il Directed in by		4 Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	irm, street, factory, office		City or Town, Si		Rural Route Number,	
_	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director; After this certificate he completed filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, only one) 3 Certifying Nurse Practioner: To the best of my knowledge, only one)	or investigation, in my opinion,	death occurred at the t	time, date and pl	lace, and due to thuse(s) and manner:	e cause(s) and manner stated.	
	Vithi Vithi Com		29b. Signature and title of certifier	29c. License nu	umber (0 8 9 2)	29d.	Date signed (Mor	nth, Day, Year)	
	OF.		29b. Signature and title of certifier MOHAMMED A 2 2 30. Name and address of person who completed cause of death (Item 23a) Moh ammed A 2 12 31. Date filed (Month, Day Year) 2010 32. Fegistrar's Signature	(Type, Print) Ontirtan	St. Haca	erstou	n 2171	10	
	Sta	te_	31. Date filed (Month, Day Year) 2000 32. Degistrar's Signature,	1	- i i i i i		2,7		
	Registr	ar	JUL I 3 ZUIU Server S.	park					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2.40 P.M L. BUNCH, SR 09 HMOUD 67 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ST-THOMAS MORE Hyattsville COMPLEX MEDICAL Birthplace (State or Foreign Country) Date of Birth (Month, Day) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours 1**X** M 2 □ F 70 Charleston, S.C 11/13/1939 Director 579-52-1771 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State ed other than "natural", or items 23a or 28a-f show event, the "wedgall Evan increment to notified at D.C. Washington 1 Tx Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with U.S.A. 20019 3457 Clay St., N.E. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 Tyes 2 No If Yes, Give 59-161 Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □ Yes 2√□ No Black Specify: Specify: <u>ک</u> 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mentai Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic event, in "Metsonge. NASA Elementary/Secondary (0-12) College (1-4or 5+) Director/Photography Dept. 2 yrs. U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Grant Leon Bunch ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4651 N.H.Burroughs Ave., N.E., #202, Wash., D.C. 20019 Pamela Denise Bunch/Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Removal from State Quantico Nat'l. Cem. 07/19/10 Triangle, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Henry S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 arz 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) month **Physician** eneis ral /Medical Due to (or as a consequence of): Examiner TLOSCI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) burial physician the burial Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. the 9 Unknown ģ been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been siç r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No death. n 24 hours after death.

e Funeral Director: A letely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

4

31. Date filed (Month, Day, Year)

423 Bullusbury Ad Hyattsville MB 2078,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 NO

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ :00 AM B716 rances Inese 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Georges Prince Georges Hospital center 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗹 Months Hours Min (Month, Day, Country) Director or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🗡 No 11105ttav 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after comparant of Health and Mental Hygiene. Important: If fem 27 is marked other than "natural", or i any injury or other traumatic event, the Marianian once. 0 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 1664 Oil Industr Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ nirz Sinclair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>20185</u> Drald Byrd-Husbar Beecher MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) heltenham 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Home 22314 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and one cause on the cause on the cause of the cause on the cause of the cause on the cause of the cau 23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final Approximate Interval Between Onset and Death Physician⊭ disease or condition Medical resulting in death) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last P.O. Box 68760 yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month 5 Other (specify) Pregnant at time of death signed by the at d be detached for ☐ Yes ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Completed by Records, 3 Probably 4 Unknown 1 Yes No 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s autopsy certificate 1 Yes 2 No 2 Division of Vital the funeral director, 25. Was case referred to examiner? Be 26. Place of Death (Check only one. Hospital Other: 2 1 🗌 Yes 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Manner of Deal Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at (Month, Day, Year) Natural 5 Pending work? 24 hours after death. Funeral Director: Ai 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier within 2 To the F the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

23a) (Type, Print)

3001 17

completed cause of death (Item

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Juny MARJORIE GROVES COPELAND Per. 2010 2:38 Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick 2100B Whittier Drive #207 Frederick Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Sept. 5, Year) 911 Director 286-14-1313 98 Ohio Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 2100B Whittier Drive #207 21702 U.S.A. or items 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 24 No by Black White etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give "natural", Specify: White 3 X Widowed 4 Divorced Completed Year or Dates. traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Rile Groves Agnes Phena Shafer permit. Page 1 and 2 should by Department of Health and Mer Important: If Item 27 is mark any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5926 Taneytown Pike, Taneytown, MD 21787 Diana Haines / Daughter Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 🕏 Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Smithsburg Crematory
7/12/2010 Smithsburg, Maryland 4 Donation 5 Other (Specify) ROBERT L. DATLEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, Due to (or as a sequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cauca. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No 4 ☐ Pregnant 9 ☐ Unknown been signed by the sahould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Renal Paringle 24a. Was an Jas page 2 autopsy performed certificate 2 🗷 No 1 Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 - Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 🕱 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Living Fore it 1 X Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

within 2 To the I

only on 29b. Signature

Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas

Thonson

32. Registrar's Signature

29c. License number

Dr

acker

D 51643

Fredenich

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death COLLEGE Month Physician/ JOSEPH ALLEN TITT. Medical 4a. Facility Name (if not institution, give street and number)
FREDERICK MEMORIAL HOSPITAL 4b. City, Town, or Location of Death Examiner 4c. County of Death FREDERICK FREDERICK 8. Date of Birth 9. Birthplace (State or Foreig May 18, 195 Washington DC. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign Funeral Months 215-58-7574 56 **Director** Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10h. County 10d. Inside City Limits Directo Frederick Frederick Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 USA 215 S. Jefferson Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes XXNo
If Yes, Give Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖁 No 3 ☐ Widowed A Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Independent Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked o ည Robert Η. Crone College Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5403 76th Ct., Hyattsville, Maryland 20784 Paul R. College Health tem 27 pernit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 4 Donation 5 Other (Specify) Blair Cemetery 7/16/2010 Blair, Pennsylvania 21. Signature of Funeral Service Ucensee M-00849 22. Name and Address of Facility
Lochstampfor Funeral Home, Inc.
48 S. Church St., Waynesboro, Pennsylvan a 23a. Part 1. Enter the disease, or complications that cause 1 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition SCLEROSIS Physician/ DMYOTROPHIC LATERAL Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami sician and burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 5 Other (specify) Pregnant at time of death g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
 1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of DOO 61410 2010 W

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GAFFAR SYED 801 TOLL HOUSE Hy, FrEDERICK MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 23534 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2ďľb 10^y 21:05 PM Ada Joan Dixon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 Union Hospital of Cecil County E1kton 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign County) North East Mary Land **Funeral** (Month, Day Year) 36 1 □ M 2🗶 F Months Davs Hours Director Jan. 74 215-34-5137 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 X Yes 2 No Maryland Ceci1 North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21901 307 River Road 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Was Deced... Armed Forces? 1 ☐ Yes 2XXNo Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: If Yes Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Education Cafeteria Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Florence Erma Reynolds Alfred L. Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 River Road, North East, Maryland 21901 Wade A. Dixon / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State Mayerdale Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2010 Newark, Delaware 21. Signature | Fonerul vice Lia 22. Name and Address of Facility Crouch Funeral Home South Main Street, North East, Maryland21901 Approximate 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Kes DIKA HOL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner homi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine physician and s the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 wonth 1 Yes 2 No 9 Unknown onths? Month Day Year 5 ☐ Other (specify) Pregnant at time of death signed by the a d be detached f 9 Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COCONARY 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy perform this certificate 2 No 1 Yes After this certifical funeral director, p **Division of Vital** 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 💢 No 1 🗌 Yes 욘 1 X Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Natural work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: Al death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

State

3

MIS

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day $A^{\ M}$ **Physician** Ju₁v 14 2010 0210 Dorothy I. Day /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Elkton Cecil Elkton Care and Rehabilitation Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 □ M 2 👿 F West Virginia AUG 11, 1924 Director 207-16-2545 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be nuffled at 1 ☐ Yes 2 📉 No Director Wilmington Delaware New Castle the 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number with United States 19805 1 Walnut Avenue Funeral death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ∐Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 👿 No Specify: þ White 3 ¥ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supermarket Checker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nora McMillan Claude Reeves ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 231 N. Bohemia Avenue, Cecilton, MD permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tra Nancy James/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July 16, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Hockessin Friends Cemetery 2010 Hockessin, DE 22. Name and Address of Facility 21. Sign sure of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic Bordingline PULMONANT Physician 同ると STAGE /Medical Due to (or as a consequence of) DILEASE Examiner CARDIOMYOPATHY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DIABETES MELLITUS Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 2 **X**No certificate 1 ☐ Yes this certifical 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Warsing Home 5 - Residence 6 - Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After 1 Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director; d in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide n 24 hours aft e Funeral Di etely filled ir 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier ical within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 000 65733 7/14/10 MO

State Registrar NARAZANA.

31. Date filed (Month, Day, Year)

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126 A

parks

E. HIGH

STREET

ISLKTON MD 21921

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V. PULA

32. Registrar's Signature

Census

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•		Certificate of Death	Reg	2010	23536
	Physicia	n/	Decedent's Name (First, Middle, Last) Susan Kay Donnelly		2. Date of Death July 12,	Day Year	3. Time of Death 2:30 p M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death	2:30 p M
_ ′	, 		Holy Cross Hospital	Silver Spring		Montgomer	
H	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 🗷 F 7. Age (In yrs. last birthdo	Months Days Hours Min		9. Birthpla Country Wisc	ce (State or Foreign onsin
	show dat	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	100	d. Inside City Limits		
	e Mary 28a-f notifie)irec		Spring			1 Yes 2 No
	if flied within 72 hours after death with the Maryland tal Hyglene. ad other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 8715 Second Avenue	10f. Zip Code 20910		9. Citizen of What Country USA	ls.
	death items		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puert 	pecify Yes or No- to Rican, etc.)	14. Race - American Black, White, etc	
036	rs after ral", or Exami	ed by	1 Never Married 2 Married 1 Yes 2 Mo If Yes, Give 1 Year or Dates.	1 ☐ Yes 2¾☐ No Specify:		Specify: Whi	
15-0	72 hou "natu ledical	Completed	(Specify only highest grade completed) (G	ecedent's Usual Occupation live kind of work done during most of work	rking 16	6b. Kind of Business Indu	stry
212	within giene. er thar the M		Elementary/Seconday (0-12) College (1-4 or 5+)	e. DO NOT use retired) Volunteer	c	ommunity Se	rvice
altimore, Maryland 21215-0036	be filed ental Hyg 'ked oth ic event,	To Be	17. Father's Name (First, Middle, Last) Kenneth Carl Buesing		me (First, Middle, Mai	,	
37	1 and 2 should be file of Health and Mental I f item 27 is marked o r other traumatic eve		<u> </u>	lailing Address (Street and Number or Ru	n Matteson		del
ž.	nd 2 sh salth ar n 27 is er trau		Shaun Edward Donnelly/Husband	8715 Second A			
lore	ge 1 ar or of He or oth		1 Burial 2 X Cremation 3 Removal from State cemetery,	isposition (Name of crematory or other place)	July 14,	oc. Location - City or Tow	
Ħ	permit. Page Department o Important: If any injury or once.	- 49	4 Donation 5 Other (Specify) 21. Signature of Puneral Service Licensee	i		Alexandria,	
ñ	Dep any any	h 30	I Cenoliew & Cole	Prancis J. Collins 500 University Bly	Funeral vd. W., Si	Home Inc. Iver Spring	, MD 20901
			23a. Part 1. Enter the disease, or comblications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final	enter the mode of dying, such as cardiac	or respiratory arrest,		approximate nterval Between Onset and Death
	hysician/ Medical		disease or condition resulting in death) a. Cardiac Arrest Due to (or as a consequence of):				Tiset and Death
	Examiner	_	Sequentially list conditions Stage IV Breast	Cancer			
_	of L of	Examiner	if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury)				
	tificate be executed ng physician an as the burial-transit	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8760	ate be physici the bu	Medical	d				
Ó	iji g		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	• □ 5 · · ·		23d. Date of delivery	
	is law requires that the death cert has been signed by the attendir je 2 should be detached for use	Physician/	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		Month D	ay Year
P.O.	requires that the been signed by t should be detach	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	cause of death?
ds,	quires t en sign uld be	ed by			1 ☐ Yes	2 😾 No 3 🗌 Proba	oly 4 🗌 Unknown
ၓ	law rec nas bec e 2 sho	Completed			24a. Was an autopsy	prior to comp	y findings available pletion of cause of
# #	The ate pag		25. Was case referred to medical	26. Place of Death (Che	performe 1 Ves 2	d? death? ▼No 1 ☐ Yes 2	□ No
Vita	nysicia nis cert directe	To Be	examiner? 1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 🖾 ER/Outpa	Other:		ce 6 Other (Specify)	
0	Jing Pt J. After th funeral		27. Manner of Death → Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) injury injury	y work?	28d. Describe how	injury occurred	
Sio	Attence or death	Certificate:	2	M 1 ☐ Yes 2 ☐ No street, factory, office		et and Number or Rural Re	oute Number,
2	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,		building, etc. (Specify)		City or Town, S	State)	
	Hosp 24 hou Funel eted fil	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea (Check close) 1 Certifying Physician: To the bests of examination and/or of only one) 3 Certifying Nurse Practioner: To the best of my knowledge.	vestigation, in my opinion, death occurred	at the time, date and p	place, and due to the cause	
	To the vithin To the compl		only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowleds 29b. Signature and title of certifier	29c. License number		I. Date signed (Month, Da	
	3		My A. Shah NT	D6405/		7/12/20	110
(30. Name and address of person who completed cause of death (Item 23a) (Typ Anuj A. Shah, MD 1500 Forest 0	_{e,Print)} Glen Road, Silver S	Spring, MD	20910	
	Stat Registra	_	31. Date filed (Month, Day, Year) 32 Registrar's Signature	faces			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep State of Maryland / Dep Registrar Ce	ertment of H Artificate of D	lealth and M <i>leath</i>		ene 2010	23537	
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Hugh N. Donovan			2. Date of Death Month July 1	Day 2010 Year	3. Time of Death 4:45 P M	
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or			4c. County of Dea	th	
~~~			Arden Court of Silver Spring	Silver	Spring		Montgom		
ı	Funeral Director		5. Social Security Number  577-40-0763  6. Sex 1 ☑ M 2 □ F  7. Age (in yrs. last birthday)  79  Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 1)	Year) 31 Was	rthplace (State or Foreign ountry) hington, DC	
	and show at	ō	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Lo	ocation				10d. Inside City Limits	
	Maryla 18a-f	Director	Maryland   Prince George's   Hyattsv	ille				1 X Yes 2 □ No	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		10e. Street and Number 6808 Shepherd Street	10f. Zip Code	0784	10	ng. Citizen of What C USA	ountry?	
	death r	Funeral	Armed Forces?	Was Decedent of His If Yes, specify Cuban	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Amo Black, Whit		
9500-612	rs after ral", o Exami	ed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates.	1 ☐ Yes 2 🖾 No	Specify:			hite	
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פ	filed w tal Hyg d othe event,	o Be	17. Father's Name (First, Middle, Last)		18. Mother's Name		aiden Surname)		
ryland	should be file and Mental 7 is marked of raumatic eve	υ	Hugh Donovan  19a. Informant's Name/Relationship (Type, Print)  19b. Mail		Helen Hi				
, Mar	nd 2 sho ealth an n 27 is er trau		1000	ing Address (Street ar <b>Shepherd</b>					
saltimore,	ge 1 ar at of H, at if iter or oth		TE Bullar 2 Es Oremation 5 El Memovarillo motate	matory or other place	9)		20c. Location - City o		
	nit. Pa artmer ortant injury			an Cremator  2. Name and Address		/2010   1		, Virginia imore Avenue	
ñ	Per Dep any any					e, P.A.	Hyattsvil	1e, MD 20781	
l,			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ter the mode of dying	, such as cardiac o	r respiratory arres	t,	Approximate Interval Between Onset and Death	
	Medical		disease or condition resulting in death)  a. Dementia  Due to (or as a consequence of):					5 years	
	Examiner	Į.	Sequentially list conditions, b.						
	red J Insit	amine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Gause (Disease or lingury						
	cate be executed physician and s the burial-transit	dical Examiner	that initiated events c. Due to (or as a consequence of):						
200	cate be physic s the bu	Ψ	d						
20 X 02	ending use as	an/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal death 3	Ectopic pregnancy	,		23d. Date of de	elivery	
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7.	s that the greed by the details of t	by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause give	en in Part I.		acco use contribute to		
g	equire	eted	History of stroke					Probably 4X Unknown	
vitai Records,	The law ate has b page 2 s	Completed by	Type 2 Diabetes			24a. Was an autopsy perform	prior to death?	rtopsy findings available completion of cause of	
<u>ra</u>	certific rector,	Be	25. Was case referred to medical examiner?  1   Yes 2 No   Hospital: 1   Inpution: 2   EP/Output:	Tother	ce of Death (Check				
0 0	g Physer this neral di	te: To	27. Manner of Death 28a. Date of injury 28b. Time of	of 28c. Injury	at 2 Nursing Hor	me 5 Residen 28d. Describe how	oce 6 Other (Spec injury occurred	cify)	
0	tendin leath. lor: Aft the fur	Certificate:	2 Accident Investigation		Yes 2 □ No				
DIVISION OF	al or At s after of the Direct		4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	1	28f. Location (Stre City or Town,	eet and Number or Ru State)	iral Route Number,	
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1  Certifying Physician: To the best of my knowledge, death (Check only one) 3  Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinior	n, death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.	
	To th To th comp	~	29b. Signature and title of certifier	29c. License			d. Date signed (Mont		
			- Tower -	D43237		Jt	ıly 13, 20	10	
	8		30. Name and address of person who completed cause of death (Item 23a) (Type, Paul Armstrong, 14201 Laurel_Park_D	ŕ	to 102 T	aurel N	VID 20707		
	Stat		31. Date filed (Month, Day, Year)  JUL 1 4 2010  32. Registrate Signature		LE 104, I	aurel, I	۷۵/07 س		
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Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated

30. Name and address of person who completed cause of death (Item 23a), (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Betty Virginia Eshelman Ju₁v 2010 08:46 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1424 Marshall St. Washington Hagerstown Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🔼 F Months Days Hours Min April 21 Mary land Director 86 <u> 220–16–1726</u> Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Washington Hagerstown ö 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 1424 Marshall St. 21740 U.S.A. or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. δ 1 Never Married 2 Married ☐ Yes 2 🗙 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Page 1 and 2 should be filed within 72 hours aft nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Communication Supervisor traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Castle Maurice Florence Viola Bragunier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pam Darden / Friend <u> 2284 Pine Rd. Newville, Pennsylvania 17241</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I 1 Burial 2 Cremation 3 Removal from State injury 4 Donation 5 Other (Specify) Rest Haven Cemetery 7/15/2010 | Hagerstown, Maryland 21. Sign of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel  $\lambda$ 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) 121 MON/N Medical Due to (or as a consequence of) Examiner YDRAT MONTHS Sequentially list conditions, if any leading 1, immediate cause. Enter Underlying Cause (Disease or injury Examine Due to lor as a consecuence of that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant a detached n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director, After this certificate has been sign completed filled in by the funeral director, page 2 should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ၉ 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier A Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d, Date signed (Month, Day, Year) VF

State Registrar

VO

11110 medical

32. Pegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PPPZZ004

Rel

Ste

130 Hogerston

17/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 1 - For State Registra Certificate of Death Req. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Easter 7:20 Am Lawrence 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Silver Spring Woodside mp If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 927 5 Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 100M 2□F 82 241-36-6721 North Carolina December 2. Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28e-f ahow 1XYes 2 No Directo Prince Georges Maryland Capitol Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō United States 607 Larchmont Avenue 20743 or Itams 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ZYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: If Yes, Give Year or Dates: þ 3 XWidowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry avent, the Madical Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction 2nd grade Carpenter permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If itam 27 is marked any injury or con-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mamie Carter Tobe Easter 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 19a. Informant's Name/Relationship (Type, Print) Laura Elizabeth Easter (Daughter) 607 Larchmont Avenue; Capitol Heights, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July 14,2010 1 □ Burial 2 Cremation 3 □ Removal from State Chesapeake Crematory, Inc. Beltsville, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility R. N. Horton Company Morticians, 21. Signature of Funeral Service Licensee Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 andays 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COPD /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner law requires that the death certificate be executed burial-transi Due to (or as a consequence of) the attending physician and Division of Vital Records, P.O. Box 68760 Physiclan/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4

☐

Pregnant at time of death 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Thinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy perform 1 ☐ Yes 2 TNo Phyaician: 25. Was case referred to medical examiner? Be director 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA S L 27. Mann of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: Attanding After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. M 2 Accident Diractor 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 - Homicide 0 filled hours Funaral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 6 H67624

Registrar
DHMH 17 Rev 1/2001

State

Spring, mo

20910

4

32. Registrar's Signatu

Silver

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avenue

2nd

JUL 1 4 2010

9101

31. Date filed (Month, Day, Year,

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Physician /Medical Examiner To Be Completed by Funeral Director

	Please 1					nk. Ensure A	-		.egible.	
1 - For State Registrar		State of N	/laryland			of Health and I <i>of Death</i>	wental Hy	/giene Reg. <b>Q</b> . (	AIO	2251.1
	e (First, Middle, Last	)					2. Date of De	eath	<b>U</b>   <b>U</b>	3. Time of Death
	-,	_	rcia				Month 6 1	Day	2010	2125 PM
4a. Facility Name (If	f not institution, give				4b. City, To	wn, or Location of Death		4c. (	County of Deat	
shady G		d ventist		ital		kville		ma	ont go r	nery
5. Social Security N	lumber 6. Se		Age (In yrs. last		If Under 1 \		(Month, Da	irth ay Year)	9. Birti Co	hplace (State or Foreign
Usual Residence of			10 -:	Tarrest Tarrest	nties					
10a. State Maryland	10b. County  Montgom	erv		own or Loc ville						10d. Inside City Limits 1 X Yes 2 ☐ No
10e. Street and Nur		J	1000		10f. Zip Co	ode		10g. Citiz	en of What Co	untry?
12526 Ve	irs Mill	Road				853			S.A.	
11. Marital Status		12. Was Deceder Armed Forces	nt Ever in U.S.	13. W		nt of Hispanic Origin? (S / Cuban, Mexican, Puerl	Specify Yes or Note to Rican. etc.)		14. Race - Ame Black, White	
	ied 2 Mamied	1 Yes 2			Yes 2⊑		, 5.0.,		Specify:	,
3 ☐ Widowed	4 Divorced	Year or Dates				Guatema	1a			White
	15. Decedent's Edu cify only highest grad	de completed)		(Give k	lent's Usual ( kind of work of OO NOT use	done during most of wor	rking	16b. Kir	nd of Business/	Industry
Elementary/Seco	ondary (0-12) 0	College (1-4o	or 5+)	e. L	N/A			N	I/A	
17. Father's Name (	(First, Middle, Last)					18. Mother's Nar	me (First, Middle		1	
Unknown						Sandra	Garcia			
	ame/Relationship (T	vpe. Print)		19b. Mailing	g Address (S	Street and Number or Ri		ber, City or	Town, State, 2	Zip Code)
Sandra G		other)		12526	Veir	s Mill Rd.,	Rockvi	11e.	MD 2085	53
_ /	position ☑Cremation 3 ☐I 5 ☐ Other (Specify,		20b. Plac	ce of Dispos netery, crem	sition (Name natory or othe		Date	20c. Loc	cation - City or	Town, State
/	neral Service Li ens			Me	Name and	Address of Facility Litan Funer ne St. Ale	al Serv	ice	56.037	
23a. Part1. Enter the	he disease, or comp	lications that caus	ed the death.			of dying, such as cardia			4.6.J.J.	Approximate Interval Between
shock, or hea Immediate Cause ( disease or condition resulting in death)	art failure. List only c (Final	one cause on each	ı line.			turity ure of				Onset and Death
Sequentially list confrant, leading to imcause. Enter Under Cause (Disease or that initiated events resulting in death) I	nmediate erlying rinjury	C	as a consequer	ice oi).	upti	rre ut	men	wra	nes	
. country in Godin) I		d	as a consequer	nce 01):						
IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [ 9 ☐ Unknown	? months?		n 2 ☐ Fetal de t at time of deat	eath 3	]Ectopic preg ]Other <i>(spe</i> d			2	23d. Date of de Month	livery Day Year
	ificant conditions co	ontributing to death	n but not resultin	ng in the ur	nderlying cau	se given in Part I.				o the cause of death? robably 4 □Unknown
							24a. Wa aut per 1□ Yes	opsy formed?	24b. Were as prior to death?	
25. Was case refer examiner?		Hospital:	atient 2000	R/Outpatient	it 3□ DOA	Othor	eath (Check only	one)		
27. Manner of Deat	th 5 Pending	28a. Date of I		8b. Time of Injury		d Nursing I c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe			ooay)
2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigation 6 ☐ Could not be determined	28e. Place of building,	injury - At home etc. (Specify)	e, farm, stre			28f. Location City or To	(Street and own, State	d Number or Fi )	iural Route Number,

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier
(Check only one)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

411110

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901 Medical Center Dr., Rockville, MD 20850

State Registrar Sherri Hamberg,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2010 15:03 John Warner Gore Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Atlantic General Hospital Berlin Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) 12/18/1938 Hours 1 🗶 M 2 🗆 F 71 **Director** 17-36-2502 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No MD Ocean Pines Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 13 Bimini Lane 21811 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: If Yes, Give white 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Regina Hardesty Wesley Gore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bimini Lane, Ocean Pines, MD 21811 Rita P. Gore / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 7/13/2010 Frankford, DE 22. Name and Address of Facility Burbage Funeral Home Berlin, MD 21811 108 William St., 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between nset and Death Immediate Cause (Final Physician/ Cancer disease or condition resulting in death) Medical Due to (or ) a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? perform 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes ER/Outpatient 3 DOA ည 1 Inpatient 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

BA5

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year

JUL 14

30. Name and address

32. Registrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)

11107 Rovetrach

29d. Date signed (Month, Day, Year)

July 13

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - State Registrar	Cei	tificate of Death	Reg.	No.2010	23543					
Physician. Medica		Gifford		2. Date of Death Month July 11,	Day 2010 Year	3. Time of Death 4:39 A M					
Examine	4a. Facility Name (if not institution, give stree	t and number) 205	4b. City, Town, or Location of D		4c. County of Death Montgor	mery					
Funeral Director	5. Social Security Number 6. Sex 1 ☐ M	2 X F 7. Age (In yrs. last birthday) 100 Yrs.	If Under 1 Year If Under 24 Months Days Hours	Mar. 8. Date of Birth  Mar. 24,	9. Birth 910 OKT	nplace (State or Foreign					
or 28a-f show notified at	Usual Residence of Decedent  10a. State 10b. County Maryland Montgomery	10c. City, Town or Lo Gaithers				10d. Inside City Limits 1 X Yes 2 □ No					
vith the Mi	10e. Street and Number 407 Russell Ave. #2		10f. Zip Code 20877	-	Citizen of What Cou	untry?					
land 21215-0036  be filed within 72 hours after death with the Maryland ental Hygiene.  ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces?	Nas Decedent of Hispanic Origin's f Yes, specify Cuban, Mexican, Pi □ Yes 2 ▼ No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh						
infilmore, Maryland 21215-0036  mit, Page 1 and 2 should be filed within 72 hours after partment of Health and Mental Hygiene.  procrant: If item 27 is marked other than "natural", o y injury or other traumatic event, the Medical Exam  To Bo Completed by	3	ompleted) (Give a life. D	dent's Usual Occupation kind of work done during most of O NOT use retired) acher	working Pr	Kind of Business Ir	rges					
/land	17. Father's Name (First, Middle, Last)  James Raymond Mims		1	Name (First, Middle, Maide TEthel Speak	en Surname)						
, Maryland Id 2 should be file saith and Mental In 27 is marked of er traumatic eve	19a. Informant's Name/Relationship (Type, F Cynthia G. Jennette	, IODI MILIM	ng Address (Street and Number of Old Hanover Rd			Code) 21158					
Imore, I Page 1 and 2 ment of Healt ant: If item 2 ury or other	20a. Method of Disposition  1   X Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	oval from State 20b. Place of Dispo cemetery, cren Arlington	sition (Name of natory or other place) National		Location - City or T						
Baltimo permit, Page Department Important: I any injury o once.	21. Signature of Funeral Service Licenson		Name and Address of Facility  Clast Deer Par	DeVol Funera	ll Home	MD 20877					
Ph sician/	23. Part 1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition)  Multi-infarction Demetia  Multi-infarction Demetia										
Medical Examiner	resulting in death)	Due to (or as a consequence of): Atrial Fibrillati	on			10 Years					
cuted nd ransit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a consequence of):									
butte be exemply sician a purial-indical E	resulting in death) Last	Due to (or as a consequence of):									
DIVISION OF VICAL RECORDS, P.O. BOX 08/00  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-fransit Medical Certificate: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	f yes, outcome of pregnancy  Live Birth 2 Fetal death 3 Pregnant at time of death 5 Unknown	Ectopic pregnancy Other (specify)	/ !	23d. Date of deliv	very Day Year					
uires that the signed by all be detailed by PP	art ii. Other significant conditions contrib	uting to death but not resulting in the u	nderlying cause given in Part I.		o use contribute to t	the cause of death?					
Hecords, The law requirect the law requirect that the page 2 should be completed.				24a. Was an autopsy performed? 1 □ Yes 2 🏋	prior to co death?	opsy findings available ompletion of cause of					
NITAL I hysician: I his certifica I director, p	25. Was case referred to medical examiner?	tal: 1 ☐ Inpatient 2 ☐ ER/Outpatien	26. Place of Death (C	Check only one)							
or Attending Phy or Attending Phy after death. Director: After this in by the funeral or Certificate: T	OZ Managa of Booth	8a. Date of injury (Month, Day, Year)  28b. Time of injury	28c. Injury at work?  M 1 2 Yes 2 No	ng Home 5 🔀 Residence 28d. Describe how inj		y)					
LIVISION tal or Attendir rs after death. al Director: After ful ed in by the ful	1	Be. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, Sta		il Route Number,					
Lthe Hospita nin 24 hours the Funeral apleted fille	29a. Certifier (Check 2 Medical Examiner: Conly one) 3 Certifying Nurse Pra	To the best of my knowledge, death on the basis of examination and/or invest ctioner: To the best of my knowledge, d	igation, in my opinion, death occurr	red at the time, date and place	ce, and due to the ca	use(s) and manner stated.					
To with with the control of the cont	29b. Signature and title of certifier	Which MT	29c. License number	29d. C	Date signed (Month,	Day, Year) 2010					
	30. Name and addess of person who complete Dr. John R. Melnick	M.D. 911 Russe	11 Ave. Gaither	sburg, MD 20	)877						
State Registrar	31. Date filed (Month, Day, Year)  JUL 14 2010	32 registrar's Signature	Med								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23544 Reg. N2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 9, 2010 Jerry Hall 6:55 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
PRINCE GEORGE 4b. City, Town, or Location of Death Examiner SOUTHERN MARYLAND HOSPITAL CENTER CLINTON 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min. 11/16/1941 Months Director 68 Maryland 216-40-3625 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland 1 Yes 2 XNo Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 6941 Public Landing Road USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Marine Year or Dates. Corp Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 Widowed 4 Divorced Corp the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of
any injury or other traumatic eve ၉ Brian J. Hall Margaret Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Hall/son 12136 Dornock Ct., Waldorf, MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 7/15/201b Spence Baptist Cemetery Snow Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ORD NARY ARTGRY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to lor as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical attending phase as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 1 Yes 2 9 Unknown Yes 2 No 9 🗌 Unknown Hospital or Attending Physician; The law requires that the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES MELLITUS HYPERTENSION Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown KIDNEY ANEMIA FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes 2 No Other: မှ 1 Impatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending injury s after death.

I Director: Aft in by the fur 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State, e Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

3 mil IVA

Box 68760

P.O.

Division of Vital

State Registrar

Day, Year) **JUL 14** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12150 ANNAPOLIS ROAD #205, MOMOH MD 32. negistrar's Signature

ATTENDING PHYSICIAN

1)52900

7-11-2010

GLENN DALE MD20769

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 23545 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/  $\operatorname{Julv}^{\scriptscriptstyle{\mathsf{Month}}}$ Paul Erwin Holly 10:50P^M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1207 B Rose Hill Ave Hagerstown Washington Social Security Number Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 17, 1958 9. Birthplace (State or Foreign Country) Maryland **Funeral** Months Days 1 № M 2 🗆 F **Director** 219-68-0716 52 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ıral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1207 B Rose Hill Ave. 21740 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married þ Baltimore, Maryland 21215-0036 1 
Yes 2 □ No Specify: "natural", Completed 3 Divorced 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " College (1-4 or 5+) Elementary/Seconday (0-12) the Insulator Commercial Building Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever ပ Carol Joyce Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Dwight L. Holly / Brother 112 Bethel St., Hagerstown, MD 21740 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory 17/13/2010 Smithsburg, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac St., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ iver cirrhosis disease or condition resulting in death) -years Medical Due to (or as a consequence of): **Examiner** typertension vears Sequentially list conditions, Examine if any leading to instruction cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Il or Attending Physician: after death. Director: After this certific Division of Vital 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) Kate 4n. Smuth 7/14/2010 CRNP R128088 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WH 2+1 opal Ct. Hagerstown, MD 21740 Kate M. Smith CRNP 1126 31. Date filed (Month egistrar's Signature State Registrar

		1 _ State	State of Maryland / D	epartment d Certificate			giene Reg. N2010	23546
	_	Registrar  1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	3. Time of Death
Physic /Medi		MILLIE M. H.	ALL			JULY	6 Day 2010 ear	11:45AM
Exami		4a. Facility Name (If not institution, give str 8607 HAMLIN ST	reet and number) REET		wn, or Location of Death ANDOVER		4c. County of Death P.G.	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	nday) If Under 1 Y Months D	ays Hours Min.	8. Date of Birt (Month, Da	y, Year) Cou	
Director		579 26 2959 Usual Residence of Decedent	92			APRIL '		S.C.
laryland show ed at	7	10a. State 10b. County	10c. City, Town					10d. Inside City Limits 1   Yes 2   No
the Ma 28a-f notifie	Director	MD. P.G. 10e. Street and Number	LAN	10f. Zip Co	ode		10g. Citizen of What Cou	21
h with 23a or st be	al Di	8607 HAMLIN ST	REET		20785		USA	
er deat tems ?	Funeral	11. Warta Statas	. Was Decedent Ever in U.S. Armed Forces?	13. Was Deceden If Yes, specify	t of Hispanic Origin? (Sp Cuban, Mexican, Puerto	pecify Yes or No Rican, etc.)	14. Race - Ameri Black, White,	can Indian, etc.
urs afte	<b>₽</b>	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1	1 □Yes 2 □	No Specify:		Specify:BLA	CK
72 hou	eted	15. Decedent's Educa (Specify only highest grade			done during most of worl	king	16b. Kind of Business/Ir	dustry
within liene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) D.	`life. DO NOT use r AY CARE	PROVIDER		PRIVATE	
Defilitiof e., Mary ylatho ZIZI3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Marical Examiner must be notified at any injury or other traumatic event, If a Marical Examiner must be notified at any once.	To Be C	17. Father's Name (First, Middle, Last) WILLIAM A. MA	SSEY	I	ne (First, Middle, STATEI	Maiden Surname)	_	
2 should and Mis mark	-	19a. Informant's Name/Relationship (Type					er, City or Town, State, Zi	
E, IN  1 and 2  Health em 27  ther tr		CYNTHIA LEE/DAU  20a, Method of Disposition			<u>·</u>	Date	ER, MD. 20	
Pages ent of ht: If ite		1 □ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)		Disposition (Name y, crematory or othe Y MEM.		4/10	LANDOVER,	MD.
Dallillor permit. Pages Department of Important: If it any injury or c		21. Sign Ture of Funeral Service Licenses	-	22. Name and	Address of Facility			20010
D SQEPS	_	23a, Part 1. Enter the disease, or complication	Alice that arrived the death. Don				h ST., N.W.	Approximate
Physician /Medical		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Cause on each line. ATHEROSCLERO:  Due to (or as a consequence of	ric card				Interval Between Onset and Death
Examiner	Į.	Sequentially list conditions, b.	Due to for as a consequence of	No.			8:	
cuted od ansit	Examiner	Sequentially is continuous, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	235 (6) 30 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					
cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequence of	of):				
ficate be ey physician s the burial	edical	d.						
box of eath certific attending p	an/Me	23b. was decedent pregnant	c. If yes, outcome of pregnancy	3 ☐ Ectopic pre	anancy		23d. Date of deli Month	very Day Year
the att	Physician/Me	in the past 12 months? 1 □Yes 2 ▼No 9 □ Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 ☐ Other (spec			Wildian	Day Tour
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	b	Part II. Other significant conditions cont	ributing to death but not resulting in	the underlying cau	se given in Part I.		tobacco use contribute to	
law requires as been sign 2 should be	leted					24a. Was		topsy findings available
The larate has	Completed						rmed?   death?	ompletion of cause of 2  No
VITAI Ician: T	Be	25. Was case referred to medical examiner?	spital:		26. Place of Dea			
J Phys g Phys er this eral dir	2	1 Yes 2 No 27. Manner of Death	28a, Date of Injury 28b, 1	Time of 280	c. Injury at		idence 6 Other (Specific Now injury occurred	cify)
ending eath. or: Afte	atio	1 Natural 5 Pending investigation	(Month, Ďay, Year) li	njury M	Work? 1 □Yes 2 □No			
or Atter	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, c	office	28f. Location ( City or To	(Street and Number or Ru wn, State)	ıral Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one)  1 Certifying Physical Examinone)	cian: To the best of my knowledge er: On the basis of examination an	e, death occurred at id/or investigation, i	t the time, date and plac n my opinion, death occ	e, and due to the urred at the time	e cause(s) and manner as , date and place, and due	s stated. to the cause(s)
To the within 3	Med	29b. Signature and title of certifier	1		License number		29d. Date signed (Monta	
		)	X	I	D19431		JULY 9 20	
5		30. Name and address of person who could FRANK M. RYAN M				TNCMON	MD 207	1.4
St	ate	31. Date filed (Month, Day, Year)	D. 11701 LIVI	/ NGSTON F	KD*F.L. MWOU	TINGTON	# PID - 20/4	<del>! '1</del>
Regist			PARTY BAR I PARTY I					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 23547 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AM 2:17 Louise Heard 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Prince Georges Lanham . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months Days Hours Min. 1 □ M 2 □X 08/15/1926 Director Alabama 423-26-0084 Usual Residence of Decedent if of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Sy Yes 2 No Maryland Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15005 Health Center Dr. 20716 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: 3 XVidowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired Operator Elementary/Seconday (0-12) College (1-4 or 5+) Jewish Home 8 Be 17. Father's Name (First, Middle, Last)
Percy Heard 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Margaret Patterson permit. Page 1 and 2 should Department of Health and M Important; If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) Grand 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Shannon Williams-Ferguson 9613 Oak Barrel Ct. Brandywine, MD 20613 daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 7/14/201d Beltsville, Maryland 4 Donation 5 Other (Specify) Chesapeake Crematory 9013 Annapolis Rendon/Hale Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. Approximate Interval Between Onset and Death hock, or heart failure. mediate Cause (Final neumonia Physician/ disease or condition resulting in death) Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or impury Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran signed by the attending physician and dbe detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an 24 hours after deatn.

Funeral Director: After this certificate has the funeral director, page 2 seed filled in by the funeral director, page 2 seed. autopsy perform death? Yes 2 No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate; 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident☐ Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certif of death (Item 23a) (Type, Print) Suite 316 Glen DAle MD 20769 OKWARA 12200 ANNAPOL: 5 ROAD State Registrar

DHMH 17 Rev 7/2009

EARD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ 2010 655 Ima June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince veoraes If Under 1 Year If Under 24 Hrs. Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 😿 Days Hours Min (Month, Day, **Director** 10c. City, Town or Location or 28a-f shov 10a. State 10b. County Defamit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 D les 2 □ No 100 10f. Zip Code 10e. Street and Numbe 380 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married þ 2 110 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry DQ NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mospita Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden ٩ Q 19a. Informant's Name/Relationship (Type, Print) (Mother) 19b. Mailing Address (Street and Number or Rural Route Number, 970 sposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crimatory or other place) 1 Neurial 2 Cremation 3 Removal from State Din 3,2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Sorvide Ed to a South 44+ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final disease or condition Onset and Death Sexticenia Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Deeuh.In Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy atten for u ☐ Live Birth 2☐ Fetal dea☐ Pregnant at time of death in the past 12 months?
1 Yes 2 No Day Month Year 5 Other (specify) signed by the a d be detached for 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an To the Hospital or Attending Physician: The law within 24 hours are death.

To the Funeral Drector: After this certificate has loompleted filled in by the funeral director, page 2 a completed filled in by the funeral director, page 2 and page 3 and page autopsy performed? Yes 2 No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 🗷 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) anacl D-25640 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) apph Ave. Suite 409 Clinton 31. Date filed (Month, Day, Year) JUL 14 2010 32. Registrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 20/0 Felicia Α. Ibitoye Iul 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death CHARLES APLATA EDICAL ENIER If Under 1 Year | If Under 24 Hrs. 1948 Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 1 □ M 2 🍎 F 62 Months Days Hours Nigeria, W.A. 220-77-9707 February Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 No Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10572 Sugarberry St. 20603 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 Married **Black** 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2yrs Government Civil Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Samue1 01ywatuyi Duduyemi Akamo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yetunde Fatoki/ Daughter 10572 Sugarberry St., Waldorf, MD 20603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Vaults and Gardens Cem. 08/06/2010 Lagos, Nigeria 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of Funeral Service Licenses 7474 Landover Rd., Landover, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23d. Date of delivery Month Day Year to use co ribute to the cause of death? 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No

**Physician** /Medical **Examiner** 

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If Item 27 is marked other ti any Injury or other traumatic event, I'm once.

**Physician** 

/Medical

Examiner

Funeral

**Director** 

ir than "natural", or items 23a or 28a-f show the Wedical Examiner must be notified at

Director

Funeral

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Completed

Be

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MD

with the Maryland

filed within 72 hours after

Examiner cal

Hospital or Attending Physician: The law requires that the death certificate be executed has been signed by the attending physician and te 2 should be detached for use as the burial-transit 24 hours after death.

Funeral Director: After this certificate

Division of Vital Records, P.O. Box 68760,

e d										
hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Yea						
be det	Part II. Other significant conditions of	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.  The Frinze Seven September 1995  Multiorgum Luclure								
Completed	Multiorgan	failure		24a. Was an autopsy findings ava prior to completion of caus death? 1 □ Yes 2 □ No						
Be (	25. Was case referred to medical		26. Place of I	Death (Check only one)						
To E	exampliner? 1	Hospital: 1 Inpatient 2 ER/Outp	Othor	g Home 5 ☐ Residence 6 ☐ Other (Specify)						
rtification: 1	27. Ma er of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Tin	ne of 28c. Injury at	28d. Describe how injury occurred						
Certific	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
Medical Certification: To Be Comp	29a. Cer fier (Ch ck only one)  1 Certifying Pr 2 Medical Exar	ace, and due to the cause(s) and manner as stated. ccurred at the time, date and place, and due to the cause(s)								
Me	29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)						

State Registrar MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chon 31. Date-filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month John P. Johnson, Jr. 3:30 PM July 10 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 208 E. Martin St. Snow Hill Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1**X** M 2□ F Months Days Hours Min 215-62-0237 57 MD June 22,1953 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Worcester Snow Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 208 E. Martin St. 21863 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No African-Specify: 3 Widowed 4 Divorced American 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Town of Ocean City 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John P. Johnson, Sr. Mary Nelson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tavonne Johnson/daughter 305 Purnell St., Snow Hill, MD 21863 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Friendship UMC Cem 7/17/2010 Snow Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 21801 21. Signature of Funeral Service Licen. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASCUN Due to (or as a consequence of): much Suc Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of d wth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 V Unknown 24a. Was an

**Physician** /Medical Examiner

permit. Pages 1 and 2 s
Department of Health at
Important: If Item 27 is
any injury or other trau

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

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Certification: To

Medical

State

Registrar

29a. Certifier

(Check only one)

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examinating the notified at

and 2 should be filed within 72 ho alth and Mental Hygiene.
27 is marked other than "natur ir traumatic event, the Western

hours after death

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Box 68760, the ding p atten signed by the a Ö ٦. Division of Vital Records, page funeral director this After

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown

28a. Date of Injury

(Month, Day, Year)

autopsy performe 1 ☐ Yes 2 ☑ No

28d. Describe how injury occurred

512 15 BU MY

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Tes 2 1 No 27. Manner of Death

1 Natural 5 Pending investigation

2 Accident 6 ☐ Could not be 3 Suicide 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Hospital:

Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 28b. Time of 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier NOM

Shell

29d. Date signed (Month, Dav. Year)

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -ble

NATERAN 1415

31. Date filed (Month, Day, JUL 14

5-DIVISION 32. Registrar's Signature

1 Inpatient 2 ER/Outpatient 3 DOA

within 24 hours after death. To the Funeral Director: A

the

filled in by

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)
Stanley R. Jaffin 2. Date of Death Physician/ Stanley July 13, Day 2010 Year 7:50 a M . Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice-Casey House Derwood Montgomery Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Days Hours Min (Month, Day, Year) 124-36-6076 64 Director New York 1946 Usual Residence of Decedent 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 🗌 Yes 2 🔀 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 USA 800 Stonington Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Hygiene. other than "natural", Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Information Technology Computer Systems Analyst Be . Father's Name (First, Middle, Last) Harry Jaffin 18. Mother's Name First Middle Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 Stonington Road, Silver Spring, MD 20902 Ann Marie Jaffin/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Miranda Cemetery Julyolo 4 Donation 5 Other (Specify) Huntingtown, Maryland 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W. Silver Spring, 21. Signature of Funeral Service Licensee MD 20901 23a. Part 1. Enter the disease. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List Ady one cause on each line. Immediate Cause (Final Onset and Death Physician/ Metastatic Colon Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami that the death certificate be executed Cause (Disease or linjury iding physician and se as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6XX Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier

P.O. Records, To the Hospital or Attending Physician: of Vital within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral to Division

> State Registrar

12

(Check only one)

29b. Signature and title of certifie

30. Name and address of person who completed can Nicole R. Christenson, 31. Date filed (Month, Day, Year)

who completed cause of death (Item

CRNP

em 23a) (Type, Print) 1355 Piccard Drive, Rockville, Md 20850 Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

R120698

29d. Date signed (Month, Day, Year,

July 13, 2010

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 1 4 Pay Physician/  $\mathtt{J}\overset{\mathtt{Month}}{\mathtt{ul}}\overset{\mathtt{h}}{\mathtt{y}}$ 2010 2:19p M L. Jones Mary Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Charles LaPlata Civista Medical Center . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Hours NOV . 18 . 19<u>30</u> Maryland 79 Director 42 4055 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland event, the Medical Examinar must be notified at Director 28a-f 1 Yes 2 No Bel Alton Md Charles 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ō Funeral items 23a 20632 9680 Faulkner Rd 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. ō 1 Never Married 2 K Married ò Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than permit. Page 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) 11th Housewife Private Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Grace Fletcher Unknown Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avra Jones/Husband 9680 Faulkner Rd BelAlton, MD 20632 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Chesapeake crematory 7-16 Greenbelt, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Priscoe-Tonic Funeral Home 21. Signature of Funeral Service Lices 2294 Old Washington Road Waldorf, MD20601 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) CANDINGHOLD DUEALE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami attending physician and I for use as the burial-transit executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Pregnant at time of death 5 Other (specify) signed by the at Id be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform Yes 2 No this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital director. 26. Place of Death (Check only one) Be examiner? 2 0 1 Tes ၉ ER/Outpatient 3 DOA 1 🗆 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) After thi funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury work? 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nuclear Proditioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of ce 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of r

on who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 23553 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:20P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Residence on Greenbelt Lanham Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🗹 F Min 86 Director 186-14-5016 /16/1924 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Prince Georges College Park ¥☐ Yes 2 ☐ No 10a. Citizen of What Country? Completed by Funeral 6100 Westchester Park Dr., #T6 20740 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene.

Tant: If item 27 is marked other than "natural", or iury or other traumatic event, the Medical Examir ury or other traumatic event, the Medical Examir 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3

✓ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Musician Music Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Yez Agnes Bozik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State) Code 20740 6100 Westchester Park Dr., #T6 College Park Joan C. Moulsdale/Daugh Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or oth cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chapel Cem 7/16/2010 Churchville, MD Smiths 21. Signature of Juneral Serv 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth
4 Pregnant
9 Unknown 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending Parter death.

Director: After t 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) 24 hours a Hospital Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature a 29d. Date signed (Month, Day, Year) 025001 -13-10

State Registrar 31. Date filed (Month, Day,

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LINTHOUM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23554 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 12:40P M 2. Date of Death Physician/ Charles S. Lightbown July 10, 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick 2244 Pleasant View Road Adamstown 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 9 /221/ 1927 577-32-3498 1 XM 2 □ F 82 Washington, DC Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Adamstown Marvland Frederick 1 ☐ Yes 2XXX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21710 Funeral 2244 Pleasant View Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 X Married White 1 Yes 2 X No Specify: 3 - Widowed 4 - Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Utilities Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Sarah ပ Charles S. Lightbown, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2244 Pleasant View Road, Adamstown, MD 21710 2244 Pleasant View Road, Mary Lightbown/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Frederick, MD 7/13/2010 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 00

Physician/ Medical Examiner

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

	Wharmy am	ille ( Ven)	1621	<u>Opossumtown P</u>	<u>'ike, Frede</u> :	rick, Ma	ryland
	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused the death ne cause on each line. a	ate Co	ode of dying, such as cardiac	c or respiratory arrest,		Approximate Interval Between Onset and Death
a Examiner	Sequentially list conditions, if any, leading to immediate cause Enter Conyling Cause (Disease or limitury that initiated events resulting in death) Last	b. Due to (or as a consequence.  Due to (or as a consequence)	, 				
edica		d					
iysician/m	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23d. Date of de Month	olivery Day Year				
nipieted by F	Part II. Other significant conditions co	intributing to death but not res	ulting in the underlyin	g cause given in Part I.	23e. Did tobacco	24b. Were au	or the cause of death?  Probably 4 Unknown  Intopsy findings available completion of cause of
5	25. Was case referred to medical					No 1 ∐ Ye	s 2 🗆 No
	examiner?	Hospital:		26. Place of Death (Che			
2	1 Yes 2 No	1 Inpatient 2	ER/Outpatient 3   28b. Time of	DOA 4 Nursing F	lome 5 Residence 28d. Describe how inju		cify)
IIcare	27. Manner of Death  1 Matural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year)					
מפונו	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify,		ory, office	28f. Location (Street a City or Town, Star		ral Route Number,
Medice	(Check 2 Medical Examin	ician: To the best of my knowled on the basis of examination of Practioner: To the best of my	and/or investigation,	n my opinion, death occurred	at the time, date and place	ce, and due to the	cause(s) and manner stated.
-	29b. Signature and title of certifier		2	9c, License number	29d. D	ate signed (Mont	h, Dav. Year)

DHMH 17 Rev 7/2009

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State Registrar 31. Date filed (Month, Day

empleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 23555 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July 9th, 2010 VIRGINIA Κ. LUDDER 8:20 a.M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mount Airy Kline Hospice House Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month_Day. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country)

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical

Examiner

For State Registrar

Physician/ Medical

**Examiner** 

**Funeral Director** 

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

	431-46-3745	81	Yrs.			1100.0		Jan 7,	19	29 Arka	ansas
₋ŀ	Usual Residence of Decedent  10a. State 10b. County	100 Cits	, Town or Lo	nantion							40-J Innido City Limito
OLDE	Maryland Frederick		unt A								10d. Inside City Limits 1 ☐ Yes 2 🛣 No
leral Di	10e. Street and Number 13220 Jesse Smith Road			10f. Zip	217	71			10g. C	itizen of What C USA	ountry?
3	1. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)										
red by	1 Never Married 2 Married 1 Yes	1 Never Married 2 Married 1 Yes 2 No								white	
neiellin	<ol> <li>Decedent's Education (Specify only highest grade completed)</li> </ol>		(Give	dent's Usu	rk done a	ation <i>luring m</i> ost	of workin	ng	16b. I	Kind of Business	s Industry
	Elementary/Seconday (0-12) 3 College (1-	4 or 5+)		no NOT use	,					Medical	1
	17. Father's Name (First, Middle, Last) James Roy Kuykendall							(First, Middle, I La S. Me			
	19a. Informant's Name/Relationship (Type, Print)  Christine Irvin - daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip.  4650 Dower Drive, Ellicott City, Maryl								ip Code) Land 21043		
	20a. Method of Disposition  1  Burial 2XX Cremation 3 Removal from State  4  Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Stauffer Crematory  7-12-2010 Frederick,										
ŀ	4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	1000		2. Name ar						eral Hor	
	Sharon Samuele	Toller					500			ick, Man	
	23a. Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on ea Immediate Cause (Final disease or condition resulting in death)	aused the death ch line. or as a consequ	19	ter the mod	e of dying	g, such as	cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
a Pydiiiici	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):										
	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths?  23c. If yes, outcome of pregnancy 1								elivery Day Year		
35	1 Yes 2 KNo 4 Pregi 9 Unknown 9 Unkn	nant at time of d own	eath 5 L	Other (sp	pecify)					WOTH!	Day Teal
, c 2	Part II. Other significant conditions contributing to de	eath but not resi	ulting in the	underlying (	cause giv	en in Part I					o the cause of death?  Probably 4 Dunknown
and in								24a. Was a autop perfor	sy me <u>d</u> ?,	prior to death?	utopsy findings available completion of cause of
	25. Was case referred to medical				26. Pla	ace of Deat		only one)	-		
	examiner? 1 Yes 2 XXVo Hospital:	Inpatient 2	ER/Outpatie	nt 3 🗆 Do	Othe	er: 4 $\square$ Nu	rsing Hon	ne 5 Resid	ence	6X Other (Spe	Hospice cify) House
	Accident Investigation	of injury h, Day, Year)	28b. Time o injury	f M	8c. Injury work 1 $\square$			8d. Describe ho	ow inju	ry occurred	
3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and City or Town, State)								ural Route Number,			
	29a. Certifier (Check only one) 3 Certifying Physician: To the bas of Certifying Nurse Practioner: 1	s of examination	and/or inves	stigation, in	my opinio	n, death oc	curred at t	the time, date ar	nd plac	e, and due to the	cause(s) and manner stated.
	29b. Signature and vitle of certifier			29c	License	number [	04	(	29d. Da	ate signed (Mont	th, Day, Year)
	30. Name and address of person who completed cause	e of death (Item	23a) (Type,	Print)	6	red	eril	06.1	Y	15 (	702
	31. Date filed (Month, Day, Year) 32. Re	egistrar's Signat	ure A	fins	the said						

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Linda 2010 Lowman Ju1v Lee Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico 105 West Lillian Street Hebron 8. Date of Birth Jan. 20, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Funeral Months Year 1961 1 M 2 X California 221-60-1684 49 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location event, the Medical Examiner must be notified at Director MD Hebron Wicomico 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or Funeral 21830 105 West Lillian Street USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 - Widowed 4 T Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M College (1-4 or 5+) truck driver transportation Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Henny Pederson Edward Fender 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce L. Fender brother P. O. Box 577, Hebron, MD 21830 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 😾 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Dorchester Mem. Park 7/15/10 Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line metro turn Immediate Cause (Final Pnysician/ disease or condition mo Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami e Hospital or Attending Physician: The law requires that the death certificate be executed 124 hours after death.

Performs after death.

Funeral Director. After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Pregnant at time of death g Unknown Part II. **Other signific**an**t conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check To the F only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 206 URASSO [VO USBURY

State Registrar 31. Date filed (Month, Day,

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 23557 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $\mathbf{J}_{\mathbf{u}}^{\mathsf{Month}}$  3, Bertha Eleanor Gibson Leonard 2010 7:14 A. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Laurel Regional Hospital Laurel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🛣 F Months Days Hours July 9, 1920 89 Yrs Director 579-34-8658 South Carolina Usual Residence of Decedent 28a-f shov 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Laurel Maryland Prince Georges 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral death with 20707 United States 9001 Cherry Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after **Black** er than "natural", the Medical Exan 1 ☐ Yes 2X No Specify: Specify: Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. D. C. Village 2 College (1-4 or 5+) Elementary/Seconday (0-12) Food Service Worker Nursing Home 12 should be filed wir alth and Mental Hygie 27 is marked other or traumatic event, ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ (Rev.) James Marie Gibson Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 4923 Goodnow Road; Apt. I; Baltimore, Maryland 21206 Pamela Gail Dixon (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of July 13.2010 20c. Location - City or Town, State permit. Page 1. Department of I Important: If ite any injury or of 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) George Washington Cemetery Adelphi, Maryland 22. Name and Address of Facility R. N. Horton Company Morticians, 21. Sonature Funeral Service Licenses Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Paset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Aspiration Pneumonitis disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical Records, P.O. Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ ó in the past 12 months?
1 Yes 2 No Month Day Year detached 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy performe death? certificate 2 No Yes 2 X No Division of Vital 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Other: မ 2 **X** No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 124 hours after death.

Funeral Director: Aff leted filled in by the fur 2 Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License numbe. 29d. Date signed (Month, Day, Year) ملان. D23685 July 4, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

JUL 1 4 2010

Peter R. Hammond, M.D.;7300 Van Dusen Road; Laurel, Maryland 20707

32. Registrar's signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 23558 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>010</u> Physician/ Month Bennie Α. Mealv 10:00AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4604 Omaha Street Heights Capitol Prince Georges **Funeral** Social Security Number Age (In vrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, 1 □ M 2 🔀 F Months Hours Min **Director** 577-46-7272 935 Georgia Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1x Yes 2 ☐ No MD PG Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4604 Omaha Street 20743 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 XMarried 1 ☐ Yes 2 🙀 No If Yes, Give Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced 1 Yes 2 No Specify: Completed Specify: Black Year or Dates the Medical 15, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Operator AT&T Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Mullins Arelia Jones 3504 Denmark Place
Bowie, Md. 20721 19a. Informant's Name/Relationship (Type, Print) Rodney Mealy/son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 7/16/10 cemetery, crematory or other place 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Md. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 gart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin . Invinediate Cause (Final Ph sician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Date to forces a co cause. Enter Underlying Cause (Disease or iinjury ig physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Month Year 1 Yes 2 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy certificate 2 No 2 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 1 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work? 1 \(\sum \) Yes 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident
Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 29b. Signature and title of icense number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

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Allentown Rd; Camp

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year Mabel E. Meilhammer Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death RIGIONAL 3448bUR 1 Com 1 Co 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H/s. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 212-78-9906 1 🗆 M 2 🔀 F Months Davs Hours 05/26/1932 78 Country) Maryland Director Yrs Usual Residence of Decedent 28a-f show mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland ardrent of Health and Mental Hygiene. ardrent of Health and Mental Hygiene ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shor ortant: If item 27 is marked other than "natural", or items be notitified at injury or other traumatic event, the Medical Examiner must be notified at "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Wicomico Hebron 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8364 Old Railroad Road 21830 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) housewife domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ڡ Benjamin Mitchell Grace Downes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Meilhammer/son 6453 Mary Jane Dr., Salisbury, MD 21801 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20b. Place of Disposition (Name of 20c. Location - City or Town, State Springhill to Memory Gardens 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/15/2010 Hebron, MD 21. Signature of Funeral Service Lice Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physiciani disease or condition Medical resulting in death) Due to (or as a c sequence of) Examiner Esque dally list outditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has eral Director: After this certificate I filled in by the funeral director, page performe 2 No Yes 2 XNo 1 Yes 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nβ(se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier D57333

Registrar

DHMH 17 Rev 7/2009

State

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CARNOll St. SAlisbury

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signatur

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene [ ] 23560 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day John Justus Meyer, Medical July 2010 21:10P 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8 Date of Birth 9. Birthplace (State or Foreign (Month, Day, 1 X M 2 □ F Months Hours Min 216-44-8956 Director 95 Dec. Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Md Montgomery Sandy Spring 1 🗆 Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20860 17340 Quaker Lane, #102 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Forces?
1 ★ Yes 2 □ No 1942-Black, White, etc Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🛮 No Specify: 3 → Widowed 4 □ Divorced 1946 Specify White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U. S. Government 12 Cryptologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bertha Cross John Justus Meyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1118 Duke Street, Alexandria, Va. Susan M. Roe / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Metropolitan Crem. 7/12/10 Alexandria, Signature of Funds Service Licenses 22. Name and Address of Facility Funeral Home Laytonsville, Muriel H. I P. O. Box Barber x 5038, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 40000 Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ☐ Pregnant a
☐ Unknown Pregnant at time of death 5 Other (specify) Month signed by the a 1 ☐ Yes ∠ ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by icate has been siç 7, page 2 should b Completed 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate I Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other; မ 1 Inpatient 2 ER/Outpatient 3 IDOA After this 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending Accident Suicide 1 Yes 2 🗌 No Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours at Funeral Dieted filled in Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the I Physicien 1)0055694 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RTIVA Olney leylonsulle Red MATHU2 20835 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William July 11, ^D2010 Lee Milburn 1:55 p^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4 Upton Court Berlin Worcester Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 80 213-26-1007 o*1%*66*7*¥936 Director Maryland Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 23a or 28a-f sho amportant: If item 27s is marked outher than "natural", or item 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or only. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Worcester Ocean Pines 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4 Upton Court 21811 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify. 3 Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) contractor elevator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Claude Willard Milburn Margaret Elizabeth Brown 19a. Informant's Name/Relationship (Type, Print)
Helen V. Milburn/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code)
4 Upton Court, Ocean Pines, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 7/13/2010 Salisbury Crematory Donation 5 - Other (Specify) Salisbury, MD Tune of Euperal Service Licensee Rolling and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 CFSP 23a. Part 1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ancistopeula disease or condition resulting in death) Medical Examiner Myeloid Leolermia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transli resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No certificate 2 🗌 No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 No ျှ Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 Kesidence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 🗌 Yes Investigation completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Name Practices: To the basis of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated. 29a. Certifier

29b. Signature and title of certifier

Macla Giller MD

Box 68760

Records, P.O.

**Division of Vital** 

Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANGLA Globs, MD 10445, Cld Ocean CFM BLVA #1, Beldin, MD 21811 . Registrar's Signa

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 05:45 Harold Lindley Murray, Sr Ju₁v Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cecil 1120 Calvert Road Rising Sun 9. Birthplace (State or Foreign County View Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aarch 31.1 **Funeral** Days Hours Min. 1**X**XM 2 □ F Director 7-36-3135 Usual Residence of Decedent "natural", or items 23a or 28a-f show diral Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 XXNo Maryland Cecil Rising Sun 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 1120 Calvert Road 21911 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, , or 1 Never Married 2 X Married Completed by 1 Yes 2XXNo 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) General Superintendent of Stone Quarry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Jeffers Murray Mary Sands 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1120 Calvert Road, Rising Sun, Maryland 21911 Marcia A. Murray / Spouse 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July Dat 10, 4 Donation 5 Other (Specify) Mayerdale Crematory 2010 Newark, Delaware 21. Signature of Tuneral Service Little 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer with Metastasis daryngeal Physician/ Unknown disease or condition Medical resulting in death) Due to (or s a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a sunsequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and-trans resulting in death) Last Due to (or as a consequence of) burialattending physician for use as the burial certificate be Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death signed by the a d be detached f 2 No 9 Unknown 9 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 20023322 Jachden 5 MD who completed cause of death (Item 23a) (Type, Print) ight, Elhton MD 21921. 10

Registrar

DHMH 17 Rev 7/2009

State

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Year

Birthplace (State or Foreign Country)

10d. Inside City Limits

Yes 2 No

Maryland

White

21158

21157

Day

3 ☐ Probably 4 ☐ Unknown

Approximate Interval Between Onset and Death

rars

Year

State Registrar 30. Name and address of person who completed cause

Year)

13

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

RNP COPPER RIDGE, 710 OBRECHT

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Month **Physician** 13, 3:46 AM Ju1y LUCILE FINAS McBRIDE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 4202 Elizabeth Street Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
April 30,1929 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 💢 F 81 Director 218-56-8299 France Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r than "natural", or Itams 23a or 28a-f shov The Medical Examinar must be notified at 1 ☐ Yes 2 X No Rockville Director Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 4202 Elizabeth Street 20853 France Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: White Be Completed by 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education permit. Pages 1 and 2 should be filled Department of Health and Mental Hyg Important: If Item 27 is marked other any rilury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marguerite Arnaud ျ Henri Finas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4202 Elizabeth Street Rockville, MD 20853 Pierre X. McBride 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) July 13, 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Alexandria, VA Metropolitan Crem. 2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licens 10 East Deer Park Drive Gaithersburg, MD 20877 urtes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** pancreatic Metastatic /Medical Due to (or as a consequence of): Examiner St. uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine nding physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 □Ectopic pregnancy in the past 12 menths?
1 Yes 2 No
9 Unknown Year Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ should be 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 25 No 24a. Was an cate has page 2 s certificate 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 27. Manner of Death 28c. Injury at Work? Certification; After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident **Director**: the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by within 24 hours after To the Funeral Direct 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10 Kville Pike, G-100, Rockville, MD 20852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1010 *[Vay* 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 14 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 23565 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Angela K. McCollin 2010 7:30 am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under Funeral 7. Age (In vrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 👿 F Months Davs Hours 10/24/1942 Puerto Rico **Director** 110-34-8712 67 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 V No Tannersville Monroe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8 Cobble Creek Drive 18372 U.S.A 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give 1 🗷 Yes 2 🗆 No Specify; Puerto Rican Baltimore, Maryland 21215-0036 3 X Widowed 4 Divorced Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 in and Mental Hygiene.
77 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Sales Person Retail Department Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julio Ramos Amelia Acevedo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Tavita Kenoly - Sister 8613 Crestgate Circle Drive. Orlando. FL 32819 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cem. 4 Donation 5 Other (Specify) 07/14/2010 Silver Spring. MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death

2 years Immediate Cause (Final Physician/ Metastatic Breast Cancer disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Breast Cancer uears Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examine Due to for as a consequence of ending physician and use as the bunial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No ō Pregnant at time of death Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Completed by Venous Thrombosis 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed' death? 1 ☐ Yes 2 🛣 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No Certificate: To 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Tyes 2 No Accident Investigation 6 Could not be Suicide 3 ☐ Sulcide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Examiners of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 D35996 July 10, 2010 30. Name and address of person who sampleted cause of death (Item 23a) (Type, Print) 2730 University Blvd.. Linda Burrell. #400. Wheaton. Maryland 20902 31. Date filed (Month, Day, Year)
JUL 1 4 2010 State

Registrar

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

		Please Type or Print in Black I		•	•					
		1 - State of Maryland / Dep Registrar Ce	artment of Health and M <i>rtificate of Death</i>	lental Hygier Reg.	2010	23566				
Physicia	n/	Decedent's Name (First, Middle, Last)  Malinda Belle McCarney		2. Date of Death	Day Zolo	3. Time of Death <i>P</i>				
Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	h				
Funeral		Washington County Hospital  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)	Hagerstown  If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	Washing 9. Bird	thplace (State or Foreign				
Director §		Usual Residence of Decedent		Jan. 30,	Ľ943   <u> </u>	laryland				
28a-f sho	Director		cation serstown			10d. Inside City Limits 1 ☑ Yes 2 ☐ No				
s 23a or uust be n	Funeral D	10e. Street and Number 383 Yorkshire Drive	10f. Zip Code 21740	10g.	Citizen of What Co USA	ountry?				
Department of Health and Mental Hygiene. Important; frems 23a or 28a-f show Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M-dir al Examiner must be notified at once.	þ	Armed Forces?  1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 ☒ No Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: <b>w</b> 1					
jiene. er than "nat the Midica	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of workir O NOT use retired) LT	ng	. Kind of Business	,				
Mental Hyg arked othe atic event,	To Be	17. Father's Name (First, Middle, Last) Chauncey Colliflower	18. Mother's Name Catherin	(First, Middle, Maide ne Arvin	en Surname)					
alth and 27 is m r traum			ng Address (Street and Number or Rural Yorkshire Dr., Hag							
nent of Heanint; If item		20a. Method of Disposition  1 ☎ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)  20b. Place of Disposition cemetery, cre  Cedar La:	natory or other place)	ı	. Location - City or	Town, State				
Departn Importa any inju once.			2. Name and Address of Facility M 15 E. Wilson Blvd.	INNICH FU						
ysician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	er the mode of dying, such as cardiac or	r respiratory arrest,		Approximate Interval Between Onset and Death				
caminer	er	Sequentially list conditions, if any, leading to immediate  b. Fsoluses (()  Due to (or as a consequence of):	Cancer							
n and al-transit	Examine	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):								
physiciar the buria	edical	d								
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician of completed filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medical		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of de Month	livery Day Year				
n signed by	کِ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1								
te has beerage 2 shou	Completed			24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of				
certifica rector, p	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Input light 2 ☐ EP/Output light 2	26. Place of Death (Check	only one)						
er this neral di	te: To	27. Manner of Death 28a. Date of injury 28b. Time of	nt 3 □ DOA	me 5 Residence 28d. Describe how in		ify)				
er death. rector: Aff by the fur	Certificate:	1	M 1 ☐ Yes 2 ☐ No	28f. Location (Street City or Town, Sta		ral Route Number,				
nours an Ineral Di d filled in	Medical Co	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death		d due to the cause(s)	and manner as sta					
thin 24  the Fu  mplete	Mec	(Check only one) 3 ☐ <b>Certifying Nurse Practioner:</b> To the best of my knowledge, 29b. Signature and title of certifier		e, and due to the caus		stated.				
3 ¥ 8		macen ms	D00508	3/3 7	1/13/1/	)				
5		30. Naturate address viberoph Mocampilete Cause of death (Item 23a) (Type,	Print) Hazerstonn	ma,	21790					
Stat Registra	e ir	31. Date filed (Month, Day, Year) 2010 32. fegistrar's Signature	iare							

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 23567 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $J_u^{\text{Month}}$ □2010 9 Joan Garrett Mowbray 2:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester 10 Merryweather Drive Cambridge 8. Date of Birth (Month, Day, Oct. 11 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2X F Maryland 0c<u>t.</u> Director 217-42-5303 67 1942 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must he notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Dorchester Cambridge 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 10 Merryweather Drive 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Maryland 21215-0036 ≥ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give 1 ☐ Yes 2 🔀 No Specify. white Specify: 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) licensed practical nurse hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David P. Garrett Lucille Parrott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John L. Mowbray Jr. 10 Merryweather Drive, Cambridge, MD son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Our Lady of Good Counsel Churchyard 1 KBurial 2 Cremation 3 Removal from State 7/13/10 Secretary, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge. 23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events soulding in death). Examine and -transit Due to (or as a consequence of): resulting in death) Last burial-1 attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ō Month Day Year 5 Other (specify) the g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been significate has been significant. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident (Month, Day, Year) 5 Pending work' 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

the

(Check

only one)

30. Name and addre

29b. Signature and title of certifier

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

29c. License number

3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2010 MADIE HELEN NICHOLS 3:10 AMMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Braddock Heights Vindobona Nursing Home 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 T Months Days Hours. Min. Julieth, 4 ay, 19a9 26 Westry)Virginia 233-38-1334 84 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick 1 Yes 2 X No Mary1and ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 items 23a U.S.A. 146 Melrose Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 → Widowed 4 □ Divorced Specify: White "natural" Completed er than "natur the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Meat Cutter Grocery Store of the and Mental Hygien 27 is marked other the traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Charles Clyde Morris Evelyn Lee Shriver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 146 Melrose Court, Frederick, MD 21702 Patricia A. Nichols / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State Smithsburg Crematory 7/12/2010 Smithsburg, Maryland 4 Donation 5 Other (Specify) Signature of F neral Service Lic ROBERT E. DATLEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET STREET, FREDERICK, MD 21701 23a. Part 1. Enter the disease, or complications that causineck, or heart failure. List only one cause on each e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, DISEASE Approximate Interval Between CHRONIC Onset and Death Immediate Cause (Final OBSTRUCTIVE PULMONARY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 ☐ Live Birth
4 ☐ Pregnant
9 ☐ Unknown in the past 12 months? Month Pregnant at time of death signed by the a 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No 1 ☐ Yes 2 ☐ No Yes Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Investigation the

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and P.O. Box 68760 Records, **Division of Vital** filled in by

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Certificate: 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier JULY, 12, 2010 MD DO061410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK, MD GAFFAR TOLL HOUSE SYED

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 23569 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 11, Day 2010 Year Physician/ William George Pittarelli 10:24 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Country)
Ttaly Social Security Number **Funeral** 7. Age (In vrs. last birthday 1***** M 2 □ F Days Min. Feb. 11, Year 1925 226-44-8727 85Yrs Director Usual Residence of Decedent 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🏲 No Maryland P.G. Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7030 Hunter Lane 20782 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Agronomist Federal Government of Health and Mental Hygie If item 27 is marked other r other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) becan Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve any injury or other traumatic eve မှ Ernesto Maria Pittarelli Irma Bianchini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rachel S. Pittarelli/Wife 7030 Hunter Lane, Hyattsville, MD 20782 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ¥⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State July Gate of Heaven Cemetery 2010 4 Donation 5 Other (Specify) Silver Spring, Maryland Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J Collins Funeral Home Inc. 500 University Blvd. W.. Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consecutions of attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown ns certificate has been s. director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has a completed filled in by the funeral director, page 2.8 autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 X No မှ npatient 2 ER/Outpatient 3 DOA . Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

14

address of person/who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Amend #30 per HD, Registrar DOR/7/14/10,LDB 23570 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1507 Juan nde JULY 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ambridge Dorchester General Hospital dichester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 213-29-1860 Year) 1□ M 21 F Months Days Hours Min. Director Marylano 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Evantine must be notified at once. 1 res 2 No Funeral Director MD Dorchester ambridge 10e. Street and Number 10g. Citizen of What Country? ZL S A Avenue Jrn Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify Maryland 21215-003( ģ Specify: Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturine Worker Line 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be harles Cornis Inez ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cambridge MD: 210
Date | 20c. Location - City or Town, State MD: 21613 Marlene Devon Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zoar 13 110 ambridge emetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOME, Henry Funeral H 510 washington 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ambridge Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or a a equen of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or ac attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: signed by the attending be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 □No 1 ∐ Yes 2 🗷 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21613 116 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

4 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ РМ Price Anna Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7504 Blanford Dr Fort Washington Prince George If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 TF 94 01/25/1916 (1) 578-16-3446 Washington DC **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George Fort Washington 1 🗌 Yes 2 ื No 10e. Street and Numbe 10f. Zip Code 20744 10g. Citizen of What Country? U.S.A. Funeral 7504 Blanford Dr 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify. Specify: Black 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Silk Finisher Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Montgomery Cora Burrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Shields(Daughter) 3759 Minnisota Ave NE Washington DC 20019 Apt #2 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other planting of the p 1 😾 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7/16/2010 Suitland Md ^{22. Name and Address of Facility}Roger J Mason Funeral Service 908 Kennedy St NW Washington DC 20011 21. Simatur of uneral Service I lasen sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ture. List only one cause on each line. Approximate Interval Between Onset and Death heart Immediate Cause (Enal disease or condition resulting in death) Physician ongestive Medical Due to ( r s a consequence of) **Examiner** Sequentially list conditions, if any, leading to minimaliate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown g 🗌 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown s after death.

I Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2XX No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5XX Residence 6 Other (Specify) 2 🖾 No 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Experiment On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Grifflying Nyrac Fractionar To the basis of examination and/or investigation, in my opinion, death and place and due to the cause(s) and manner at example. 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

of person who completed cause of death (Item 23a) (Type, Print)

anna

10-05182

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

enneth Reese	1- For State Certificate of Death											
Physici		Registrar  1. Decedent's Name (First, Midd	lle,Last)		· ·			2. Date of De			of Death	
ledical Exami			Reese					Month July 10,	Day Year 2010	203	36 hrs	
)		4a. Facility Name (if not institution	on, give street and nu	,		•	, or Location of	f Death	4c. County o			
		Western Maryland Re				Cumberl			Allegany			
Funeral		5. Social Security Number		7. Age (In yrs. I	ast birthday)	If Under 1		Min.	Birth (MM/DD/YYYY	Country)		
Director		220-86-0857	1XM 2 F		40 Yrs			Dec.1	5,1969	Wash.	,DC	
any		Usual Residence of Decedent 10a. State 10b. County		I10c. City.	, Town or Local	tion				10d. In:	side City Limits	
<u> </u>			ton		Colleg		•				Yes 2 No	
Maryland 28a-f show 1 at once.	cto	10e. Street and Number				10f. Zip Cod			10g. Citizen of Wh	at Country?		
ith the Maryland 23a or 28a-f sho notified at once	Director	2255 Shance	v Lane			303	349		United	State	s	
with t		11. Marital Status		edent Ever in U		as Decedent of	Hispanic Origi	n? ( Specify Yes or N	lo- 14. Race	- American India		
death r iten	Funeral	1 X Never Married 2 M	larried Armed Fo	2 X No	lf Y	es, specify Cu	ıban, Mexican,	Puerto Rican, etc.)	White	, etc.		
after	by F		vorced If Yes, Give Year	r	1	1 Yes 2 X No specify:			Specify:	Black	<u> </u>	
hours natur Exam	ed	15. Decedent's Education (Spe					upation (Give ki life. DO NOT u	ind of work done use retired)	16b. Kind of Bus	siness/Industry		
36 in 72 han "	Bet	Elementary/Secondary (0-12)	College (1	-4 or 5+)	C	onetri	uction		Pri	vate		
5-0036 led within 7 Hygiene. other than	Completed	17. Father's Name (First, Middle				Olisti		Name (First, Middle				
215 be file ntal Hy rked o	Be (	Edward Walt	·				Jac	queline	Reese			
21 ould der d Mer s mar		19a. Informant's Name/Relations			19b. Mailin	g Address (S	treet and Numb	per or Rural Route No		nber, City or Town, State, Zip Code)		
MD id 2 sh lith an m 27 i		Jacqueline W	<i>l</i> alton/mc		<u> </u>	lege I	ncey L Park,	GA 3034	9			
ore, s l an of Hea If ite.		20a. Method of Disposition  1 Bunial 2 X Cremation	n 3 Removal fro		Place of Dispos crematory or ot			7/21/10	20c. Location -	City or Town, S	tate	
E Donation 5 Other Specify: Riverdale Park Crematory Riv							Riverd					
Salt ermit. Separt mpor njury		21. Signature of Funeral Service	Licensee	/ .				Hodges &				
	_	23a. Part I. Enter the disease, or	complications that ca	aused the death				ill Rd.,			XU / 4 6 eximate Interval	
Physician /Medic I		failure. List only one cause	on each line.							Betwe	een Onset and Death	
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. <u>Perica</u> Due to (or as a			age wit	n Tampo	onade (Non-	Traumatio	2)	4.0-	
	.	Sequentially list conditions,	b									
	ie.	If any leading to immediate cause. Enter Underlying Cause		consecuence o	n):							
	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence o	f):							
be executed ician and urial - transi			d	22			-007 (	) 0 10	<del> </del>			
	adical	X UNPENDED	AMENDED	23a,pt	.11,2/	per me	g907 S	9-8-10 vt				
Box 68760 e death certificate the attending physed for use as the b	cian/Me	IF FEMALE; 23b. Was decedent pregnant in the	23c. If yes, o	outcome of preg		etal death	3 Ectopic	pregnancy	23d. Date of o	delivery Day	Year	
x 6. h cert tendir	<u>S</u>	past 12 months?	4 Pregna	ant at time of de	oth -	her (Specify)		F 3,		,		
Bo te dear	Physic	1 Yes 2 No 9 Uni	9 OTIKITO					1				
F.O. B ires that the de signed by the 1 be detached f	P P	Part II. Other significant condit			-		•		tobacco use contrib es 2 No 3	Probably 4	_	
duires	ē	Valvular (Ao	rtic) Hear	t Disea	ise; Ao	rtic Co	arctati	24a. Was		Vere autopsy fin-		
cords, law requir has been s	ompleted	(Repaired)						auto	opsy pr	rior to completion		
tal Rec	S							1 ✓ Yes		✓ Yes	2 No	
Vital Rec ysician: The his certificate director, page	å	25. Was case referred to medica examiner?	11 21-1		ED/0-1		Othor:	Check only one)	Davidson 6	7045		
of Vir Physical this	ို	1 Yes 2 No	28a. Date	npatient 2 🗸	28b. Time of I		Injury at Work?	Nursing Home 5	Residence 6 how injury occurre	Other:		
on of anding Ph. th. r: After t	Ö	1 X Natural 5 Pend	(Month,	Day, Year)			Yes 2					
2 Accident Investigation 3 Suicide 6 Could not be determined  Sign 2 Fig. 1									r or Rural Route	e Number, City		
							State)					
Selection of the cause (s) and manner as stated.  Contact only one of the cause (s) and manner as stated.  Contact only one of the cause (s) and manner as stated.  Contact only one one one of the cause (s) and manner as stated.  Contact only one							e to the cause	s)				
- 3 - 3	ž	29b. Signature and title of certific	er .		)		ense number		29d. Date signe		Year)	
		11/1/12		1111		О.	C.M.E.		July 11, 201	10		
		30. Neige and address of person			,	Penn Stra	et Baltimor	- MD 21201				
		Russell Alexander MD		edical Exam gistrar's Signatu			et, baitimol	re, MD 21201				
St Regist		31. Date filed (Month, Day, Year)		gratiar a digridit	The L	whol						

DHMH 17 Rev 1/2001 OCME 2006

10-05203 Salvator Ramos

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 23573 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day 1820 hrs **Medical Examiner** Salvador Rudi Ramos 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Montgomery Silver Spring 2533 Ross Road Apt. T If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** oreign El Salvador Months Days Hours 42 Director 216-57-1588 07/09/1968 1 X XM 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 XYes 2 No Gaithersburg 23a or 28a-f show notified at once, Montgomery Maryland permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants. If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at ource. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code El Salvador 8 Brighton Ct. 20877 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes Specify: White 1 X Yes 2 No specify: Salvadorian 3 Widowed 4 Divorced If Yes, Give Year ě 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Maintenance EID Lake 12 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Haydee Bonilla Max Ramos Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) ပ 8 Brighton Ct. Gaithersburg, MD 20877 Max Ramos (Brother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State Silver Spring 07/16/2010 Gate of Heaven Maryland 4 Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Lice Rendon/Hale Funeral Home Annapolis Rd. Lanham, MD 20706 Approximate Interval art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death a. Pulmonary Thromboembolism Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Deep Vein Thrombosis Of Right Leg Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last transit The law requires that the death certificate be executed /sician/Medical AMENDED UNPENDED attending physician or use as the burial -23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Year Live birth 3 Ectopic pregnancy Fetal death 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o र्व 1 Yes 2 No 3 Probably 4 V Unknown σ. Completed Records, 24b. Were autopsy findings available 24a. Was an certificate has been prior to completion of cause of autopsy performed' ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical of Vital Be examiner? Other Nursing Home 5 Residence 6 🗸 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 this 1 Yes 2 No 28d. Describe how injury occurred After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c, Injury at Work? 27. Manner of Death 1 🗸 Natural 1 Yes 2 No Division Director: Pending death Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City within 24 hours after To the Funeral Direc Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DOME July 12, 2010 O.C.M.E. who completed cause of death (Item 23a) 30. Name and address of person

State Registrar

**ORIGINAL** 

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registra 's Signature

Theodore M. King, Jr., MD.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, G907, 9772010, WS, 20c
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Becky Robertson July 22:06 PM ďg^y 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Clinton Southern Maryland Hospital Prince Georges If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 01-28-195 Louisiana 461-96-1377 **Director** 59 Usual Residence of Decedent show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director MD Prince Georges Bowie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 15106 Jerimiah Lane 20721 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗵 No Specify: If Yes, Give Year or Dates Black Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 r. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ni any injury or other traumatic event, the Mediconce. College (1-4 or 5+) Elementary/Seconday (0-12) Postal Worker Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Leo Fontenot Laura Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willie 15106 Jerimiah Lane, Bowie, MD Robertson/ Husband 20721 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Harmony of Cemet elegolace) Landover 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland National Cem. 07/16/2010 Maryland Signature of uneral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral 7474 Landover Rd., Landover, MD 20785 23a. Part 1. Enter the disease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each respiratory arrest shock, or heart failure. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 호 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. Funeral Director; After this certificate has autopsy performe 2 🗌 No Yes 25. Was case referred to medical director B 26. Place of Death (Check only one) examiner? Other: ျှ 1 Yes 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred watural
☐ Accident
☐ Suic 5 Pending 1 🗌 Yes 2 🗌 No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: The best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examination the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the F only one Certifying Name Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print) State 32. Registr JUL 1 4 2010 Registrar

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar		ryidiid /	Cer	tificate of D	eath			Reg. No	201	0_	23575
	Physicia	n/	Decedent's Name (First, Middle, Lass     Phyllis	Patrick		C o I	isbury		1	. Date of De Month	Da	ay Ye	ar	3. Time of Death 12:11 P M
	Medic Examin	al	4a. Facility Name (if not institution, give			دەد	4b. City, Town, or	Location		JULY_	8,	2010 c. County of D	eath	12.111
		E1	Homewood Crumland		1th Ct:	r.	Frederi					Frede		.k
	Funeral Director		402 20 0027		In yrs. last bir 89	thday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8 Min. J	Date of Bir (Month, Date uly 2	th ly, Year) <b>7 , 1</b> 9	9. 20 N	Count	lace (State or Foreign ry) aska
	ind show	or	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Loc	ation						10	0d. Inside City Limits
	Maryla 8a-f s	Funeral Director	Maryland Freder	ick		Myer	sville							1 🗆 Yes 2 No
	h the l	al Di	10e. Street and Number				10f. Zip Code					itizen of What		
	ath wit	uner	11335 C Highland	School Roa  12. Was Decedent Eve		13 V		773 spanic Ori	igin? (Specif	v Yes or No-		ted St		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importantal if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 🙀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 N  If Yes, Give  Year or Dates.			Vas Decedent of Hi Yes, specify Cubar			ean, etc.)		Black, V		etc.
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Dalilliore	Page 1 ar nent of H. ant: If iter ury or oth		20a. Method of Disposition 1	Removal from State (fy)	cemete	ery, crem	sition (Name of natory o <b>Pan f</b> la L1e/Farm	<b>ÿ</b>	Dat 7/12/2	-	l .	ocation - City rersvil		wn, State , Maryland
ה מוני	permit. Departi Import any inj		21. Signature of Funeral Service Licens	St 11		22	. Name and Addres					neral H		
	HD = # 0		23a. Part 1 Enter the disease or com shock, or heart failure. Lest only of	plications that caused t	he death. Do	not ente	1621 Opo	ssum g. such as	cardiac or n	espiratory ar	rest,	ierick,	, 1111	Approximate
p	Trysician/		Immediate Cause (Final	ne cause on each line.	.h.co.	- A )	رار « دار دار دار دار دار دار دار دار دار دار		2					Interval Between Onset and Death
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3	tre be hysicia the bui	Medical		d									+	
DOX OO	To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  within 24 hours after death.  completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	Fetal deal		Ectopic pregnanc	y				23d. Date o Month	f delive	ery Day Year
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NISIOII.	eath. or: Aft the fur	ifica	1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be	n			M 1 🗆	Yes 2						
2 :	In the hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2:	Certificate:	4 Homicide determined	28e. Place of Injur building, etc.	y - At home, f (Specify)	arm, stre	eet, factory, office		28	If. Location ( City or To	Street a wn, Stat	nd Number o e)	r Rural	Route Number,
ָ ב	pspital hours ineral d filled	Medical	29a. Certifier ertifying Phy	rsician: To the best of m	ny knowledge	, death o	occured at the time	, date and	place, and	due to the ca	ause(s) a	and manner a	s state	d.
	the Ho nin 24 the Fu npleter	Med	only one) 3 Certifying Nur	iner: On the basis of exa se Practioner: To the b	amination and/ est of my knov	or invest	leath occurred at the	e time, dat	te and place,	and due to the	he cause	e(s) and manne	er as sta	
	<b>5</b> 20 00 00 00 00 00 00 00 00 00 00 00 00		29b. Signature and title of certifier	Par			29c. License		, 00	,	29d. D	ate signed (M	ionth, l	Day, Year)
J			30. Name and address of person who	completed cause of dea		(Type, F	Print)	7 0	् <i>७</i>			,		7 4
	6		Austin Pearre,	300 West 9	th Str	eet	, Frederi	ck,	MD 217	701				
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	A.	parke							
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Patricia Hope Smith 2010 Tu 1v 10:28 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Center Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign CounBaltimore Maryland 7. Age (In vrs. last birthday 8 Date of Birth **Funeral** (Month, Day, Year, Hours Min 1 □ M 2XXF Director 1954 216-52-4366 56 or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the M. dical Examiner must be notified at Director 1 Yes 2XXNo Maryland Ceci1 North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21901 107 Erie Court United States death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes XX No If Yes, Give Year or Dates. Maryland 21215-0036 hours after 1 Yes 2 No Specify White 3₩idowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Rehabilitation Addiction Counselor Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be to Department of Health and Menta Important: If item 27 is marked Burton Barrett Thompson Frieda Awilda Baughman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Erie Court, North East, Maryland Julie Burdette / Daughter Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July Dit , injury or 5 Other (Specify) 4 Donation Mayerdale Crematory 2010 Newark, Delaware 21. Signature era Service Licenses 22. Name and Address of Facility Crouch Funeral Home any 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that odused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate name. Exercise the darking Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) 9 Unknown P.O. I à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC KIDNEY DISEASS Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an certificate has autopsy MPHUSEMA Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 No Hospital Other: 4 Nursing Home 5 Residence 6 X Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending work?
1 Yes 2 No 1 X Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JULY 5, 2010

State Registrar 6701 N CHARLES ST, SUITE 4105 BALTIMORE, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DOBERMAN, MA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Justy 13, Day 2010 Year Physician/ 9:30 A M Minnie SCHECTER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda 5807 Ipswich Road If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2√□ F Months Days Hours Jumeth, 13 Year 1929 Pemms Ivania 81 206-20-7104 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a, State Director 1 Yes 2 X No Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20814 5807 Ipswich Road 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married within 72 hours after Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white "natural", 3 XWidowed 4 ☐ Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ဂ္ Sadie Miller Nathan Vederman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1400 Fallswood Drive, Potomac, MD Randi Shakin, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 07/15/1D Olney, MD Memoria<u>l Gardens</u> Judean 21. Signature of Funeral Service Licensee Torchinsky Hebrew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death Immediate Cause (Final Ischemic Cerebrovascular Accident Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Parkinson's - Plus Syndrome Sequentially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exami that the death certificate be executed Due to (or as a consequence of) resulting in death) Last burialattending physician Physician/Medical Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 - Fetal death in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed i rector, page 2 should be det þ 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No or Attending Physician: The 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 X No 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify, 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 X Natural 5 Pending 24 hours after death.

Funeral Director: A 2 Accident Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Type Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only of 29d. Date signed (Month, Day, Year) July 13, 2010 29b. Signa 29c. License number MD 0052247 10 30. Name and address of person who completed cause of death (New 23a) (Type Print) Colin Cullen, M.D., 7625 Wisconsin Ave., Bethesda, MD 20814

State Registrar 31. Date filed (Marth, Day Year) 2010

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a-c Per FH G906 8/03/2010 JH State of Maryland / Department of Health and Mental Hygiene State of Warylan State of Warylan State Registra AMEND#20 open FH, 7/20/10, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 07/11/2010 Vear CYNTHIA E. SCRIBNER 10:10 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Hospice Towson Baltimore If Under 1 Year Social Security Number 9. Birthplace (State or Foreign **Funeral** 6. Sex 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth Days Hours 1 □ M 2X F 1072471924 Bahamas 85 Director 216-42-0753 Yrs Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2X No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 3911 Southern Cross Drive 21207 USA death . 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or δ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental P Important: If item 27 is marked o မ Houston Johnson Olivia Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ashley T. Collins - nephew 3911 Southern Cross Drive, Baltimore, MD 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State  $7 - 26^{ate} = 2010$ Ardelity Cremation SV Woodlawn Cemeter Burial 2 XX remation 3 - Removal from State injury or Hanover 4 Donation 5 Other (Specify) Signature Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, of complication shock, or heart failure. List only one cau complication Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ midearding disease or condition Medical resulting in death) Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? ρ 2 No 3 Probably 4 winknown Completed 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy perform director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 - Nursing Home 5 - Residence 6 - Souther (Specify) WYS A CO 2-2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 烂 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Getting Nurse Praction of Total basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the and title of certifier 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) ٩ 010 Name and add ss of person who completed cause of death (Item 23a) (Type, Print) 701 31. Date filed (Month, Day, Tear) Registrar's Signature State 14 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2010 Alan Craig Stoller 12 4:50 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14011 Weeping Cherry Drive Rockville Montgomery 8. Date of Birth (Month, Day, 09 / 22 / Birthplace (State or Foreign Country)
 New Jersey Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Days Hours 1 X M 2 D F Director 47 154-66-6363 1962 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 🗌 Yes 2 🔀 No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 U.S.A. 14011 Weeping Cherry Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Real Estate Finance Senior Vice President injury or other traumatic event, permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy
Legyportant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Stoller Elaine Canin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robyn A. Stoller - Spouse 14011 Weeping Cherry Dr., Rockville, MD 20850 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗍 Removal from State 4 Donation 5 Other (Specify) Garden of Remembrance 07/13/2010 | Clarksburg, Maryland 21. Si nature of Funeral Se vice 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. M00709 11800 New Hampshire Ave., Silver Spring, MD20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Onset and Death Ph_sician/ disease or condition Metastatic Sarcoma Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examir sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available has page 2 prior to completion of cause of death? performed? After this certificate 2 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital ပ 1 Tyes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending (Month, Day, Year) injury death. 1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide within 24 hours after death

To the Funeral Director: ,
completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year, 10 DC19655 July 12, 2010

State

Registrar

32-Registrar's Signature

3800 Reservoir Road, NW, Washington, DC 20016

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Marshall, MD,

14 201

31. Date filed (Month, Day, Year)

JIII

OCME

Claude Barton Sr		, III S	tate of Marylan	d / Depa	rtment o	f Healt	h and	Mental	Hygiene	:	2010	23580
		tegistrar  1. Decedent's Name (First, Midd	de Last)	Cer	uncate of	Deau			2. Date of	Reg.	No.	3. Time of Death
Physicial Medical Examin		Claude Barton							Month		oay Year O	0258 hrs
		4a. Facility Name (if not instituti		er)		4b. City, T	own, or Lo	ocation of De		,	4c. County of Dea	ith
	4-	Washington County I	lospital			Hager	stown				Washington	
Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. la	ast birthday)		r 1 Year	If Under 24		of Birth	(MM/DD/YYYY) 9 E Fore	Birthplace (State or
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Claude Barton 19a Informant's Name/Relation			19h Mailin	a Address			Arlene		er, City or Town, Sta	ite Zin Code)
	리	Jacqueline R.		- -							own, MD 2	
and 2 sho ealth and tem 27 is	ł	20a. Method of Disposition	DILLETT WII	20b.	Place of Dispo	sition (Nan	ne of ceme		Date		20c. Location - City	
Baltimore, permit. Pages 1 at Department of Hee Important: If ite Injury or other tr		1 Burial 2 X Crematic		State	crematory or of			O'	7_15_2	امتد	Ungorato	wn,Maryland
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Box te death c the atten	hys		nknown 9 Unknow					une in Best I	220	Did tob	acco use contribute	to the cause of death?
Division of Vital Records, P.O. Box 6876( the Hospital or Attending Physician: The law requires that the death certificate thin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending phy- inplietely filled in by the funeral director, page 2 should be detached for use as the b	b F	Part II. Other significant cond	itions contributing to a	leath but not r	esulting in the	undenying	cause gi	ren in raiti.	1 [			robably 4 Unknown
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of Vital Records, ng Physician: The law requir ther this certificate has been as	Be (	25. Was case referred to medic examiner?					10		eck only one) ursing Home	ε [] o	tesidence 6 Ot	har
f Vit	ို	1 Yes 2 No 27. Manner of Death	28a. Date of		ER/Outpatier 28b. Time of			at Work?			ow injury occurred	ilei.
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Division Hospital or Attendii 24 hours after death. Funeral Director: /	Certification:	2 Accident Inv	restigation 28e Place (	of Injury - At h	ome, farm, stre	et, factory	, office bu	ilding, etc.				Rural Route Number, City
Div tal or rs after	ertif		uld not be termined (Specify)	Single Far	nily				17307 C	own, Sta Claymor	ate) nt Drive, Hagersto	wn, MD
Division Attention of Attention of Attention of Attention of Attention of Function of Function of the Attention of the Attent		29a. Certifier 1 Certifying	Physician: To the best of	of my knowled	lge, death occu	urred at the	time, dat	e and place,	and due to th	e cause	(s) and manner as s	tated.
To the within 2	Medical	one) 2 Medical Ex	caminer: On the basis of and manner stat		and/or investig				ed at the time	e, date a		
To To COD	Me	29b. Signature and title of certi		A		29	c. License				29d. Date signed (i	Month, Day, Year)
ALC:		all	111				O.C.N	1.E.			July 12, 2010	
ti		30. Name and address of person				04	L Delle	more MD	21201			
3		Zabiullah Ali, M.D.	Assistant Medica			ıın Stree	e, baitil	more, MD	21201	_		11.7
St	ate	31. Date filed (Month, Day, Yea	9000 32 Kgg	istrar's Signat	uie A	m she	q					

Jivision of Vital Records, P.O. Box 68760	Baltimore, Maryland 21215-0036
Il or Attending Physician: The law requires that the death certificate be executed	permit. Page 1 and 2 should be filed within 72 hours after death with the Ma
	Department of Health and Mental Hygiene.
Director: After this certificate has been signed by the attending physician and	Important: If item 27 is marked other than "natural", or items 23a or 28a
d in by the funeral director, page 2 should be detached for use as the burial-transit	any injury or other traumatic event, the Medical Examiner must be noti

	1	For State Registrar	State of Mai	ryland		artment of I rtificate of I		ind Me	ental Hy	giene Reg. Né	20	10	23581
Physician/	1	Decedent's Name (First, Middle, Las	t) <b>C.</b>		STEWA	RT		1	2. Date of De Month <b>JULY</b>			Vear	3. Time of Death 4:25 A M
Medical Examiner	4	a. Facility Name (if not institution, give				4b. City, Town, o	r Location of			4c	. County	of Death	γ
Funeral	5	HOLY CROSS HOSPI  Social Security Number  6. Se		In yrs. Ia	st birthday)	If Under 1 Year Months Days	If Under 2		3. Date of Bir	th		9. Birth	place (State or Foreign
Director	l	577-52-8036 Usual Residence of Decedent	M 2 LAF	72	Yrs.	Mioritals 2 349	1,100.0		MAY 2:	2 1	938	NOR'	TH CAROLINA
f show ed at	1	0a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside City Limits 1 √√ Yes 2 □ No
or 28a-f sho or 28a-f sho e notified at Director	1	MD PRINCE G	EORGE'S	LAR	lGO	10f. Zip Code				10g. Ci	tizen of V	What Cou	41
tems 23a c er must be Funeral		160 GREEN MEADOW	WAY #B			2077				US.	A		
by by	·	Marital Status     Never Married 2      Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1  Yes 2  N If Yes, Give Year or Dates.		13.	Was Decedent of Hard If Yes, specify Cub	an, Mexican,	in? (Speci , Puerto Ri	fy Yes or No- can, etc.)			k, White,	ean Indian, etc. BLACK
rithin 72 hours a lene. r than "natural" the Medical Ext		15. Decedent's Ed (Specify only highest gra			(Give	dent's Usual Occu kind of work done	during most	of working	,	16b. K	(ind of B	usiness In	dustry
within / giene. Sr than the M the M		Elementary/Seconday (0-12)	College (1-4 or 5+)	)	NUR	OO NOT use retired  SE				GO	VERN	MENT	
sintal Hyg ced othe c event,		17. Father's Name (First, Middle, Last)					l .	r's Name ( <b>RGIN</b> ]	First, Middle,	, Maiden VING		e)	
nould b	$\vdash$	JAMES COVINGTON  19a. Informant's Name/Relationship (Ti	/pe, Print)		19b. Mail	ing Address (Street	and Numbe	r or Rural I	Route Number	er, City or	r Town, S		
and 2 si Health a Health a Her tra		ROLAND E. STEWART	!/HUSBAND	Look B	160	GREEN 1	MEADOW						
age 1 a ent of H nt: If ite y or ot	1	20a. Method of Disposition  1		C	emetery, cre	osition (Name of matory or other pla	ce)	7/14	/2010				own, State  ARYLAND
permit. P Departm Importar any injur once,		21. Signature of Funeral Service Licens		DII		2. Name and Addr 7474 LA	ess of Facility	, J.	. B. J	ENKI	NS F	UNER	AL HOME
physician and horizotransit the burial-transit edical Examiner		23a. Part 1. Enter the disease, or comshock, or hart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any hadring to firm south cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last		RESI consequ EXACI	PIRATO ence of): ERBATI ence of:	RY FAILU		cardiac or	respiratory a	rrest,			Approximate Interval Between Onset and Death
attending for use as cian/M	1 2	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 24 No g  Unknown	23c. If yes, outcome of 1  Live Birth 2  4  Pregnant at 1  9  Unknown	☐ Feta	death 3	☐ Ectopic pregnar	псу					ate of deliventh	very Day Year
signed b	1	Part II. Other significant conditions on ESRP	ontributing to death but	t not res	ulting in the	underlying cause o	iven in Part I						the cause of death?
cate has been signage 2 should the Completed	ĺ	CAD							24a. Was	s an	24b.	Were auto	opsy findings available ompletion of cause of
cate ha		СНЕ							perf 1 🗌 Yes	ormed? 2 XN	lo	death? 1 🗌 Yes	2 <b>X</b> No
nis certifi I director,	-1	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital:	nt 2 🗆	ER/Outpatio		Place of Deather:		only one) ne 5 $\square$ Res	idence	 6 □ Oth	er (Specit	iy)
After thi		27. Manner of Death  1 Natural 5 Pending	28a. Date of injury (Month, Day,	Year)	28b. Time o injury	wo	ry at rk?	28	3d. Describe				
The nospital on Attending Priysicals. The law requires that the but within 24 hours after death.  To the Funeral Directors After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached Medical Certificate: To Be Completed by Physi		2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined					Yes 2	-	8f. Location City or To			er or Rura	al Route Number,
in 24 hours in 24 hours he Funeral pleted filled		(Check 2 Medical Exam	sician: To the best of miner: On the basis of exa se Practioner: To the b	amination	and/or inve	stigation, in my opir	ion, death oc	curred at t	he time, date	and place	e, and du	ie to the c	ause(s) and manner stated.
vithin To the comp		29b. Signature and title of certifier	2011001011101100	000	, naiomougo	29c. Licen	se number						Day, Year)
10		30. Name and address of person who	completed cause of de	ath (Item	23a) (Type,	Print)	0395	201 =			T	ODD 3	INC. NO. 20010
State		TAZAH 31. Date filed (Month, Day, Year)	AIBDULS 32. Register	's Signal	A M	M - 1	ノ 118	801 T	ECH RI	SI	LVER	SPR.	ING,MD 20910
Registrar		JUL-1 4 2010 Z	Zeres D.	100	wer								

		1- State Amend Item 25 1	per me, g906	08/06 Ce	72010dhb rtificate of L	Death	з мептат ну	giene Reg. No.	2010	23582
Physic		1. Decedent's Name <i>(First, Middle, Last)</i> James Stanley	Sims Jr.				2. Date of De	ath Day	Year 2010	3. Time of Death
/Med Exam		4a. Facility Name (If not institution, give street			4b. City, Town, or		ath	-	County of Death	
Funera Directo		5. Social Security Number 6. Sex 196-14-8210	7. Age (In yrs. la			If Under 24 H Hours M	rs. 8. Date of Bir	th y, Year)	DRCHE 9. Birth Cou	place (State or Foreign intry) ISylvania
Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County MD Dorchester		, Town or Lo	cation Cambr	idge				10d. Inside City Limits 1 ☐ Yes 2X No
h with the I	al Director	10e. Street and Number  3 Nanticoke Road			10f. Zip Code	21613		10g. Citiz	zen of What Cou USA	intry?
yidilid XIXIS-0030  uid be filed within 72 hours after death with the Maryland Mental Hygiene.  arked other than "natural", or items 23a or 28a-f show afte event, the Medical Evancian from the neithed at	by Funeral	1 Never Married 2 X Married 1	das Decedent Ever in U.S rmed Forces? ☑️Yes 2 □ No Yes, Give WWII ear or Dates:		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ☑No	ispanic Origin? In, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		4. Race - Amer Black, White, Specify: Wh	
Ivial y Idilia Z IZ 13-0030 d 2 should be filed within 72 hours aft th and Mental Hygiene. 77 is marked other than "ratural", or traumatic event, the Madical Event traumatic event,	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)  C	. U	(Give life.	dent's Usual Occup	during most of v l)		16b. Kir	aircraf	
laryland 212 Should be filed within and Mental Hygiene. is marked other than aumatic event, the Me	To Be Co	12 17. Father's Name (First, Middle, Last) James Stanley Sims		ere	ctrical e	18. Mother's N	Name (First, Middle Clotte Ni		Surname)	
Vielr 12 sho th and 7 is m traum		19a. Informant's Name/Relationship (Type. P. Nancy Sims	rint) wife	1	ng Address <i>(Street :</i> nticoke R				Town, State, Z 21613	ip Code)
DallIIIIOTE, I permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	al from State		osition (Name of matory or other plac of Delma	i	Date 12/10		cation - City or T	
Dalti. Permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	)	22	2. Name and Addres	ss of Facility T	homas Fu	neral		
Physician /Medical		resulting in death)	ns that caused the death. use on each line.  Due to (or as a consequence)	Do not ent	ter the mode of dyin	g, such as card	diac or respiratory a	rrest,		Approximate Interval Between Ponset and Death
Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a son sequi				2/11	EXAMINER		
oor ou, tificate be executed g physician and as the burial-transit	ledical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	ence of):	ď	ERTIFICATION	PROVED BY MEDICAL			
The law requires that the death certificate has been signed by the attending phyage 2 should be detached for use as the	Physician/Medi	in the past 12 months?	yes, outcome of pregnar  □ Live birth 2 □ Fetal □ Pregnant at time of de □ Unknown	death 3	☐ Ectopic pregnanc				23d. Date of deli Month	very Day Year
law requires that the as been signed by 2 should be detact	þ	Part II. Other significant conditions contribut	ing to death but not resul	Iting in the u	nderlying cause give	en in Part I.	23e. Did			the cause of death?
	Completed						1 Tyes	psy ormed? 2 No	24b. Were au prior to death? 1 □ Yes	topsy findings available completion of cause of
ysician: 7 is certifical director, pa	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospit	al: 1 Inpatient 2 ☐ E	ER/Outpatier	nt 3 □ DOA Oth	er.	Death <i>(Check only o</i> g Home 5 ☐ Resi		3 ☐ Other (Spec	cify)
ding Ph	ion: T	1 Natural 5 ☐ Pending		28b. Time o Injury	f 28c. Injur Work	y at ⟨? Yes 2 □ No	28d. Describe	how injury	occurred	
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific; completely filled in by the funeral director, to	Certification:	2 Cuiside 6 Could not be	e. Place of Injury - At hor building, etc. <i>(Specify</i>	me, farm, str		163 2 110	28f. Location ( City or To	Street and wn, State	d Number or Ru	ral Route Number,
Hospit 24 hour Funera etely fills	edical (	29a. Certifier 1 Certifying Physiciar (Check only one) 2 Medical Examiner:	n: To the best of my know On the basis of examination	vledge, deat ion and/or in	th occurred at the tire envestigation, in my o	me, date and pl pinion, death o	ace, and due to the ccurred at the time	cause(s) date and	and manner as place, and due	stated. to the cause(s)
To the within To the comple	Med	29b. Signature and title of certifier	D		29c. Licens			29d. Dat	e signed (Month	n, Day, Year)
10 1/		30. Name and address of person who comple	ted cause of death (Item	23 <b>a</b> ) (Type,	Print)	3238	1	Jul	m 1	10(0
100	ate	31. Date filed (Month, Day, Year)	(00) 32. Registrar's Signati	Brau		to Ca	am brie	19e	6111	21613
Panie		.1111 1 3 2010	4 1	ha	dal					

JAMES SIMS Y

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item 25 State of Maryland Department of Health and Mental Hygiene Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 10 Zon VIG /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 🗆 M 2 🖫 F Months Days 214-28-7928 JAN. 22,1 Director Maryland Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 1 ¥Yes 2 □ No Director Cambridg MDDorchester 10g. Citizen of What Country? 10e. Street and Number 242 12. Was Decedent Ever in U.S. Armed Forces? 21613 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced 'natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) al Hygiene. County Board of Ed. rentary teacher + 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. Be Camper Manue tarriet ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 427 Cambridge Beltway Cambridge, MD. 21613
of Disposition (Name of Date 20c. Location - Oty or Town, State Monroe Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State rist Rock Cemetery 17/10 Cambridge 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Henry Funeral Home, r. 77 , Sio washington Str Combri Funeral Home, dge,MD,21613 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** Intracerebra disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last TION APPROVED BY MEDICAL EXAMINER Examiner Due to (or as a consequence of) or Attending Physiclan: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) CERTIFIC Box 68760. attending physiciar Physician/Medical as IF FEMALE nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year ate has been signed by the atten page 2 should be detached for i 4 Pregnant at time of death
9 Unknown Dav 5 Other (specify) 2 No PO. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate director, 26. Place of Death (Check onl one) Be 25. Was case referred to medical Other: 4  $\square$  Nursing Home 5  $\square$  Residence 1 X Yes Z No 1 XInpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) မ within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1X Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (check only one) within 2 To the F 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

RES-000

600 North Wolfe St, Baltimore, MD, 21287

rattalone, MD

ONE

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fratta

Anthony

31. Date filed (Month, Day, Year)

JUL 15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23584 Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death JULY 23 2010 STELLA PLEKAN TOMSON

4b. City, Town, or Location of Death

**Physician** /Medical **Examiner** 

Director

Funeral

2

Completed

8 ဂ

1 - For State Registrar

4a. Facility Name (If not institution, give street and number)

**Funeral** Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Welfort Examinat must be notified at 72 hours after filed within 7 Hygiene. d 2 should be filed w. th and Mental Hygier 7 is marked other th

/Medical Examiner

Examine attending physician and for use as the burial-transi funeral director, this

To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral 6

Baltimore, Maryland 21215-0036 or other tra permit. Pages 1
Department of H
Important: If iter
any Injury or oth **Physician** Box 68760, Ö σ, Division of Vital Records,

Physician/Medical

ģ

Completed

Be

Certification: To

Smith Creek Assisted Living Cecil Warwick 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year Hours Months Days 1 M 2 TF 94 May 6 1916 073-03-8583 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County DE New Castle Wilmington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19810 1410 Windybush Rd. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Theodore Plekan Catherine unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kathleen E. Taylor (daughter) 1410 Windybush Rd. Wilmington, DE. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/24/10 Kent Cremation Smyrna, DE. 22. Name and Address of Facility
Galena Funeral Home of Stephen L Schaech 21. Signature of Fulleral Servix M00510 118 West Cross St. Galena, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Cerebrovascular Accident Immediate Cause (Final disease or condition resulting in death) Alheroscleratic Heart Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

9 Unknown

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 MNo

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death 5 Other (specify) 9 Unknown

Due to (or as a consequence of)

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 Ectopic pregnancy

Month

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Day

23d. Date of delivery

4:13a M

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

19810

Approximate Interval Between Onset and Death

Un known

unknown

New York

4c. County of Death

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manper of Death 1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier (Check only

4 ☐ Homicide

5 Pending investigation

6 ☐ Could not be

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Nother (Specific Specific Control of Cont 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29b. Signature and title of certifier

Jackelew S MD

29c. License number 20023322 29d. Date signed (Month, Day, Year) 7.23.2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

Sheelmohan S. Sachdev, M.D. 126 E. High St. Elkton, MD. 21921

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

10-05374 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Ruthenia Thomas 1-For Statemended 4a Facility Name ekt. Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Medical Examiner 2002 hrs July 18, 2010 lee 4c. County of Death 4b. City, Town, or Location of Death 706 Talbot 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY **Funeral** Months Hours 4-82-9698 Director 1961 ndry land Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 No or items 23a or 28a-f show must be notified at once. permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-f sho finjury or other reaumatic event, the Medical Examiner must be notified at once, nijury or other reaumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 1 Never Married 2 Married 2 1 No 1 Yes Black 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Year ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) oderick arner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 07 Meadows Drive Apt, 504 OUKS Easton. 20a. Method of Disposition 20b, Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Laston ichards Mem, Park 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOME Funeral HENTY MD. 21613 washington Str Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Amitriptyline and nortriptyline intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last signed by the attending physician and be detached for use as the burial - trans X AMENDED Physician/Medical XUNPENDED 23a, 27,28a-f,per ME g906 8/18/10 TT requires that the death certificate be 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: of Vital examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 Yes 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 1 Yes 2 X No Pending Fd 7:55 pm the state Fd 7/18/10 Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number City or Town, State) / 00 Series Doverbro St. Apt / 06 Easton, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be fo the within 24 hours the Funeral P Found: residence determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Aighature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number July 19, 2010 O.C.M.E.

State Registrar

**OCME 2006** 

**ORIGINAL** 

111 Penn Street, Baltimore, MD 21201

no completed cause of death (Item 23a)

32. Registrar's Signature

Assistant Medical Examiner

Laron Locke MD.

31. Date filed (Month, Day, Year)

JUL 22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra/MEND#1perMD, 7-22-10, BMW, McCo 1. Decedent's Name (First, Middle, Last) Verna Trahan 2. Date of Death Physician/ 201°0 2152 Verma-Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🎛 F Months Days April 29 Hours Min. North Dakota 578-58-8250 Director 82 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must he matified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Funeral Director 1 Yes 2 X No Columbia Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7080 Cradlerock Way 21045 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. Completed 3 X Widowed 4 Divorced Caucasian Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Cashier Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Edna Duval Lewis Ness 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48th Place. College Park. Maryland 20740 Joel Andrew Piccioni - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland National Cem 07/17/2010 Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final AKTHER TO SELFROTTE Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to himsediate cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det þ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) funeral director, Certificate: To Be Other: 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Investigation Accident filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

24 hours after death. Funeral Director: A office the Function of the Fun

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Don Michael Coleman II, MD, 20010 Century Blvd. #200, Germantown, MD 20874 31. Date filed (Month, Day, Year)

32/Registrar's Signature

29b. Signature and title of certifier

JUL

14

Registrar

State

57614

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

December Name (First, Models, Last)  Privation  Medical  Examination  4a. Chey Town, or Location of Death  Dorich Steff Centrol Hospital  4b. Chy, Town, or Location of Death  Dorich Steff Centrol Hospital  4b. Chy, Town, or Location of Death  Dorich Steff Centrol Hospital  4b. Chy, Town, or Location of Death  Dorich Steff Centrol Hospital  4b. Chy, Town, or Location of Death  Dorich Steff Centrol Hospital  4b. Chy, Town, or Location of Death  Dorich Steff Centrol Hospital  4b. Chy, Town, or Location of Death  Dorich Steff Centrol Hospital  4b. Chy, Town, or Location of Death  Dorich Steff Centrol Hospital  4b. Chy, Town, or Location of Death  Dorich Steff Centrol Hospital  4b. Chy, Town, or Location of Death  Dorich Steff Centrol Hospital  4b. Chy, Town, or Location of Death  Dorich Steff Centrol Hospital  4b. Chy, Town or Location of Death  Dorich Steff Centrol Hospital  4b. Chy, Town, or Location of Death  Dorich Steff Centrol  1b. Social Steff Centrol  1c. Social			1	For State Registrar	State of Marylar	•	artificate of i			2010	23587
Second Companies   Second Comp		Physicia	-	1. Decedent's Name (First, Middle, L					Month	Day Yea	3. Time of Death 2.035 PM
Social Security Number   6.	-			4a. Facility Name (If not institution, g	nive street and number)	tal.					ath
Description   The property   The p				5. Social Security Number 6.	Sex 7. Age (In yrs.	last birthday	) If Under 1 Year		B. Date of Birth (Month, Day,		irthplace (State or Foreign Country)
109. Street and Number   109. Clizzen of What Country?   109. Clizzen of What Country?   109. Street and Number   109. Clizzen of What Country?   109. Street and Number   109. Clizzen of What Country?   109. Street and Number   109. Clizzen of What Country?   109. Street and Number   109. Clizzen of What Country?   109. Street and Number   109. Clizzen of What Country?   109. Street and Number   109. Clizzen of What Country?   109. Street and Number   109. Clizzen of What Country?   109. Street and Number   109. Clizzen of What Country?   109. Street and Number   109. Street and Number   109. Clizzen of What Country?   109. Street and Number   109. Clizzen of What Country?   109. Street and Number   109. Clizzen of What Country?   109. Street and Number   109. Street   109. S	,	3		Usual Residence of Decedent	10c. Ci	ty. Town or L	ocation		109,0,	1/20 1	10d. Inside City Limits
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Physician Medical Examiner  Ph	with the	3a or 2			bridge Belt	wav		6/3	10	US)	4
Physician Medical Examiner  Ph	, e	or items?		11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U Armed Forces? 1 1 Yes 2 No If Yes, Give				ify Yes or No- ican, etc.)	Black, Wh	nite, etc.
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Physician Medical Examiner  Ph	121 within	giene.	Sompl			1	1 .	work	; \	Sameone	else's home
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Physician Medical Examiner  Ph	Mary Mary	h and M	F	19a. Informant's Name/Relationship	(Type. Print)	19b. Mai	ling Address (Street	and Number or Rural	Foute Number,	City or Town, State	e, Zip Code) 210 44
Physician Medical Examiner  Ph	ore, I	of Healt fitem 2 r other		20a. Method of Disposition	20b.	Place of Disp cemetery, cr	oosition (Name of ematory or other pla	ce) ~	ate 2	20c. Location - City	or Town/State
Physician Medical Examiner  Ph	altim mit. Pag	artment ortant: I ortant: I injury o		4 □ Donation 5 □ Other (Spe	ecify) D						lge, MD.
Physician Medical Examiner  Sequentially list conditions, if any, leading to death of the people of	B B	a m m		Janella C	L. Henry	1.6	La Mask	IINGIUN ST	$\gamma \cup u \wedge u \times v \wedge v$		MD. 21613 Approximate
Examiner  Sequentially list conditions, I any bedieved to find the property of	Ph	hysician		shock, or heart failure. List of Immediate Cause (Final disease or condition	nly one cause on each line.						Onset and Death
Sequentially list conditions, cause. Enter Underlying Cause. (Disease or injury that initiated events resulting in death) Last  Due to or as a consequence of:    Part   Other significant conditions to the cause of light and the constraint of the cause of the cause of the cause of the cause of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Due to or as a consequence of:							COPD				
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24a. Was an autopsy performed?  1	G. ta	signed by	by	Part II. Other significant condition	s contributing to death but not re	sulting in the	underlying cause gi	iven in Part I.			
	Recol	ate has beer	omplete						autops perfori	sy prior med? deat	to completion of cause of h?
25. Was case referred to medical examiner?  1 Yes 2 No  25. Was case referred to medical examiner?  1 Yes 2 No  26. Place of Death (Check only one)  1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manner of Death  28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	Vital Sician:	this certificate has all director, page 2.3	Be	examiner?	Hospital:	T ER/Outpat	ient 3 🗆 DOA Ot	than:	(Check only or	ne)	Specify)
27. Manner of Death  27. Manner of Death  1 De Natural 5   Pending investigation investigation investigation   Pending investi	n of	fter	ion: To	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time	of 28c. Inju	ury at 2			opeony)
The state of the s	Division or Attend	after death Director: .	ertificat	3 Suicide 6 Could no	ot be 28e. Place of Injury - At	home, farm,			28f. Location (S City or Tow	treet and Number on, State)	r Rural Route Number,
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)	Hospital	rospita 24 hours Funeral tefy filled		(Check only 2 Medical E	xaminer: On the basis of exami	nowledge, de nation and/o	eath occurred at the rinvestigation, in my	time, date and place, opinion, death occurr	and due to the e	cause(s) and manndate and place, and	er as stated. due to the cause(s)
29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier  29c. License number 29d. Date signed (Month, Day, Year) 7/12/10.	To the	within 2 To the comple	Med		and mariner stated.	MD				-1	fonth, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		8			NS A		pe, Print)	BURN STRE	et.		E, MD 21613
State Registrar  31. Date filed (Month, Day, Year)  Registrar  32. Registrar's Signature				31. Date filed (Month, Day, Year)	32. Registrar's Sig		alled .	- (			

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Ttems 20b, c per in 905 /-29-10 vt State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ July 10^{Day} 20^{Year}0 Tandy Carrie 3:10P Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Takoma Park Washington Adventist Hospital 8. Date of Birth 1945 (Month Day, Year) 45 April 25, If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours Min. Months 1 - M 255F South Carolina Director 577-84-8567 65 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "naturo" any injury or other traumatic average. 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No DC Washington 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 20002 USA 1661 Trinidad Ave NE 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Home Maker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Macda. Lee George Abney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2074719a. Informant's Name/Relationship (Type, Print) 6019 Parkland Crt #102 District Hgts Md Linda Moore, Niece 20b. Place of Disposition (Name of Mt. ceretarmetery or other place) 7 20a. Method of Disposition 1 ★ Burial 2 Cremation 3 Amemoval from State Brentwood 4 Donation 5 Other Spec Ronald M Taylor 11 Funeral 21. Signature 22. Name and Address of Facility Plains Md Home 10583 Middleport Ln White 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eu Physician/ MOHICE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner distress espirahm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine ng physician and as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Dav Year ρ Pregnant at time of death Yes g Unknown g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I by 1 Yes 2 10 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t page 2 s autopsy 2 🗆 No 1 🗌 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in 24 hours after use....
the Funeral Director. After this can be the funeral director in by the funeral director. မ this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Matural 5 Pending M 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge dieth commit at the time data and clara, and due to the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD 00060600 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Universey BLVD Ear 831 31. Date filed (Month, Day, Year) JUL 1 4 2010 32. Registrar's signatur State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^D2010 JULY **JOHN** TERRY JR. 4 10:15 A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S TEMPLE HILLS 6005 HOPE DRIVE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Sex 1 M 2 □ F 8. Date of Birth Month, Day, Months Days Hours Min 578-42-9974 NORTH CAROLINA 78 JAN ĩ932 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 14 Yes 2 No PRINCE GEORGE'S TEMPLE HILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6005 HOPE DRIVE 20748 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 M Married 1 ☐ Yes 2 X No Specify: BLACK Specify 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11TH GRAPHIC DESIGNER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHNNIE FREDERICK LEOLA TERRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIRGINIA TERRY/WIFE HOPE DRIVE TEMPLE HILLS 6005 MARYLAND 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State □ Donation 5 □ Other (Specify) HARMONY CEMETERY 7/14/2010 LANDOVER, MARYLAND J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service I 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death disease or condition resulting in death) <u>ATHEROSCLEROTIC</u> Due to (or as a consequence of END STAGE CARDIAC DISEASE Due to (or as a consequence oi): CHRONIC OBSTRUCTIVE LUNG DISEASE Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Pregnant at time of death Other (specify) Year

Physician/ Medical Examiner

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Physician/

Medical

10a. State

MD

Director

Funeral

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Completed

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**Examiner** 

**Funeral** 

Director

"natural", or items 23a or 28a-f shov idical Exa<u>miner must be notified at</u>

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at any injury or other traumatic event, the Madical Examiner must be notified at

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-tran signed by the a cate has been signated by page 2 should b director, funeral

cate:

27. Manner of Death

1 X Natural

5 Pending

Physician: The law requires that the death certificate be executed

certificate

of Vital Records, P.O. Box 68760

Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 A Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒No 24a. Was an autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year)

28c. Injury at

work?

28d. Describe how injury occurred

20706

DIVISIO	after Dire	- 1	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, f building, etc. (Specify)	actory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	Hosp 24 hou Fune sted fil	ا ڏ	(Check 2 Medical Examiner	r: On the basis of examination and/or investigation	on, in my opinion, death occurred	and due to the cause(s) and manner as stated.  d at the time, date and place, and due to the cause(s) and manner state  does and due to the cause(s) and manner as stated.	e
3	vithin to the comple	7	29b. Signature and title of certifier	5 1.0	29c. License number	29d. Date signed (Month, Day, Year)	_
			July Da	es MU.	D32761	JULY 7, 2010	
		- [	30. Name and address of person who com	poleted cause of death (Item 23a) (Type, Print)			_

28b. Time of

State Registrar

JALEH DAEE M.D. 9470 ANNAPOLIS ROAD # 418 LANHAM, MARYLAND 31. Date filed (Month, Day, Year) 32. Registre's Signa JUL 1 4 2010

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Olulo of Mic	ir ylaria /	-	tificate of		- IVICITE ITY		2010	23591
	Physicia	an/	Decedent's Name (First, Middle, L  JOHN	ast) FRANKLIN		WIL	, ES		2. Date of De July		^{ay} 2010 ^{Year}	3. Time of Death 1:00 A M
,***	Medi⊲ Examir		4a. Facility Name (if not institution, g					or Location of Dea		<del>.</del>	c. County of Death	
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	Funeral Director		220 10 1700	Sex 7. Age 1	(In yrs. last bir 88	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			9. Birth Cou. Mar	pplace (State or Foreign ntry) yland
	nd how at	٦	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Loc	ation					10d. Inside City Limits
	/laryla 8a-f s tified	rect	Maryland Freder	ick	Mid	ld1et	town					1 ☐ Yes 2 🔏 No
	a or 2 be no	١	10e. Street and Number	'			10f. Zip Code			10g. C	itizen of What Cou	intry?
	th with ms 23 must	Funeral Director	6809 Mountain C				2176				ted State	
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ğ	Marital Status     □ Never Married 2 □ Married     3 ☒ Widowed 4 □ Divorced	If Yes, Give Year or Dates.	40	1	Yes 2 No		Specify Yes or No- to Rican, etc.)		14. Race - Ameri Black, White, Specify: W	
15-	72 ho n "na Aedica	Completed	15. Decedent's (Specify only highest	grade completed)		(Give k	ent's Usual Occup ind of work done ONOT use retired)	during most of wo	orking	16b.1	Kind of Business Ir	ndustry
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pu	filed y	o Be	17. Father's Name (First, Middle, Las						ame (First, Middle	, Maiden	Sumame)	
yla	uld be I Meni narke natic	잍	John W.	T. Wiles				Ella	Mae			
Mai	2 sho th and 27 is r traun		19a. Informant's Name/Relationship  Judy Neal / dau								r Town, State, Zip	
re,	1 and if Heal item 3		20a. Method of Disposition		20b. Place o	of Dispos	sition (Name of		Date		ocation - City or T	
mo	Page nent c ant: If ant: or		1 🕅 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe				atory or other place vet Cem.		10,2010	Fre	ederick,	MD
Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		21. Signature of Emeral Service Lice	3 (1km		22.	Name and Addre				eral Home	
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	Medical Examiner		resulting in death)	Due to (or as a	consequence	of):						
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Box 6	ath cert attendir for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of 1  Live Birth 2 4  Pregnant at 9  Unknown	Petal deat		Ectopic pregnand Other (specify)	су			23d. Date of delive	very Day Year
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of V	Phys r this eral dir	e: To	1 ☐ Yes 2 🔀 No 27. Manner of Death	1 Inpatie		utpatient Time of	3 DOA 28c. Injur	4 X Nursing	Home 5 Resi		6 Other (Specif	y)
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Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		y - At home, fa (Specify)	arm, stree	et, factory, office		28f. Location ( City or Tou		nd Number or Rura e)	l Route Number,
	ne Hospit n 24 hour ne Funera pleted filk	Medical	(Check 2 Medical Exa	nysician: To the best of miner: On the basis of exarts Practioner: To the b	amination and/o	or investi	gation, in my opinio	on, death occurred	at the time, date	and place	e, and due to the ca	use(s) and manner stated.
	vithi To #	-	29b. Signature and title of certifier	2			29c. License	e number		29d. Da	ate signed (Month,	Day, Year)
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	8		3	andi MI)	ath (Item 23a) ( )	Type, Pr	Tou	House	Ave,	Fre	donich	tated. Day, Year)  MO 31701
	Stat Registra	T.C.	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	1.	Gara					

DHMH 17 Rev 7/2009

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23592 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death ^{Day} 2010 July 11, 0855 Marcellus William Wentz, Jr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Carroll Carroll Hospital Center Westminster If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 1 XM 2 ☐ F 219-44-8985 May 10, 1946 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MD Carroll Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21102 3241 Main St. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes ♣♠No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Hughes Trash Removal 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha Lemmon Marcellus W. Wentz, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Manchester, MD 3241 Main St. 21102 D. Ruth Wentz 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/15/2010 | Silver Run, Maryland St. Mary's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Si native of Funeral Service Mensee 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 412 Washington Rd. Westminster, MD 21157 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHRONIC ZESPIRATORY FAILURE 24814 CHRONIC Obstructive polymonary 34 Ear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MEROCALGINOM LUNG (diagnised April, 2010 1 Yes 2 No 3 Probably 4 Unknown TYPE I DUBETES Mellitus incumaled 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

The law requires that the death certificate be executed physician and the burial-transit Box 68760, attending pl Division of Vital Records, P.O. Hospital or Attending Physician: 24 hours after death.
 Funeral Director: After this certifica ettel filled in by the funeral director, p

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

27 is marked of traumatic even

Department of Health a Important: If item 27 is any Injury or other trau

Physician

/Medical Examiner

Examine

Physician/Medical

Completed by

Be

Certification: To

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Director

Funeral

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Completed

Be

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

To the within 2 To the 1

Registrar

31. Date filed (Month, Day, Year) JUL 1 3 2010



Franco K. Galus til mos

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS K. GALVIN III

parker

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

291 STONER AVENUR

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0031660

29d. Date signed (Month, Day, Year)

July 11, 2010

WESTMINSTER MARYLANGERIST

		For	Sta	ate of	Marylar	nd / Depa				and M	ental Hy	giene	e		
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	edical		d	(M	PEIC		ou	e C	Ke	M	we	<u> </u>		$\perp$	gene 6
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifi 1 Certifying (Chec 2 Medical Ex	Physician: To	o the best	t of my know	ledge, death o	ccured at	the time,	date and p	place, and	due to the cau	use(s) ar	nd manner as	stated	d. se(s) and manner stated
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DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ **Medical** 4c. County of Death Facility Name (if not institution, give street and number) or Location of Death Examiner If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. last birthday Social Security Number 6. Sex **Funeral** OCT 1953 56 Months Days Min 1 XM 2 F Hours New York 121-42-3347 Director Usual Residence of Decedent 23a or 28a-f show ist be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director Beltsville Prince George's Maryland 1 St Yes 2 No 10f. Zip Code 20705 10g. Citizen of What Country? 3702 Green Ash Court Funeral the Medical Examiner must , or items within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. Armed Forces þ 1 Never Married 2 Married Yes 2 XNo Maryland 21215-0036 Black 1 Yes 2 No Specify: If Yes, Give "natural", 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Government Corrections Officer Be 18. Mother's Name (First, Middle, Maiden Surname)
Mary Kirby filed 17. Father's Name (First, Middle, Last) David Williams ပ pe nb. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3702 Green Ash Court, Beltsville, MD 20705 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is (Wife) Vicki Williams Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 🖺 Removal from State Moravian Cemetery 7/15/2010 Staten Island, NY injury or 4 Donation 5 Other (Specify) Name and Address of Facility Latimore Funeral Services, P.A. 9013 Annapolis Road, Lanham MD 20706 Signature of Funeral Service Licers 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine ri any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events Due to (or as a consequence of) physician ar s the burial-to resulting in death) Last Physician/Medical Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day ō Month Year Pregnant at time of death g Unknown the 1 Yes 2 L signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 🗷 No certificate 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) vithin 24 hours after cleau..

To the Funeral Director: After this of ဂ္ this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury accurred Certificate: iniury 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 20a Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 [ 3 [ 29d. Date signed (Month, Day, Year) 29b. Sign 21201

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2010

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		_	For State Registrar		State of M	arylan			nt of H <i>te of D</i>		Mental Hy	giene ,	2010		2359	5
	B	,	-	e (First, Middle, Las	t)						2. Date of De	eath	Year	$\overline{}$	. Time of Death	
	Physicia Medio		Robert	Free		Asles	on				July	22 22	2010		5:50 P	M
	Examin	er	,	not institution, give	,			· '	, Town, or I hesda	Location of Deat	h		County of Deat			
-	Funeral		5. Social Security N		ex 7. Ag	e (In yrs. la	ast birthday)	If Und	er 1 Year	If Under 24 Hrs	8. Date of Bi	rth	9. Bir	thplace	(State or Forei	gn
	Director		469-32-	6694	M 2□F	74	Yrs.	Months	Days	Hours Min.	Month, Di 10/11	71935	M°	inne	esota	
	ind show at	o	Usual Residence of 10a. State	10b. County		10c. City	y, Town or Loc	ation						10d.	Inside City Limi	ts
	he Maryland or 28a-f show e notified at	rect	MD	Montgom	ery	Bet	hesda								1 🔀 Yes 2 🗆	No
	h the Sa or S	al Di	10e. Street and Nur						ip Code				en of What Co	ountry?		
	ath wit	Funeral Director	6106 Da ¹	venport T	errace 12. Was Decedent I	Ever in II.S	113 V		0817	nanic Origin? (S	pecify Yes or No	U.S	A. Race - Ame	rican Ir	ndian	-
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	þ		ried 2 🔀 Married 4 🗌 Divorced	Armed Forces?  1 K Yes 2 If Yes, Give Year or Dates.		11	Yes, spe	2 ☑ No	, Mexican, Puer	to Rican, etc.)		Black, Whit			
5-0	2 hour	plet	(Spe	15. Decedent's E			16a. Deced	ind of w	ork done du	tion uring most of wo	rking	16b. Kin	d of Business	Industr	гу	
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m m	Page nent or			☐ Cremation 3 ☐ 5 ☐ Other (Specif	Removal from State		emetery, cren atany Gi				23/2010	Han	over, i	Mary	yland	
Baltimore, Maryland 21215-0036	permit. Departn Imports any inju		21. Signature of Fu	neral Service Licens	LEO MOU	_					natomy G				D 21076	
	Physician/		hack, or hea	rt failure, List only o Final	plications that caused ne cause on each line	d the death	$\sim$			, such as cardiad		rrest,		Inte	proximate erval Between set and Death	
Ç	Medical Examiner		d ase or condition resulting in death)	on <b>f</b>	a. Due to (or as	a consequ				1 (0.	<del></del>					
	ed	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	riving	b. — See to (or as	е сыпанци	ieinde of):									
B	rate be executed physician and the burial-transit	al Exa	that initiated event resulting in death)	s I	Due to (or as	a consequ	ience of):									
2092	icate by physics the k	ledical			d											
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours a "er decth.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled — by the funeral director, page 2 should be detached for use as the burial-transition.	Completed by Physician/M	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	I death 3	Ectopic Other (s		′		2	3d. Date of de Month	elivery Day	/ Year	
P.O.	hat the	y Ph	Part II. Other signit	ficant conditions co	ontributing to death b	out not res	ulting in the u	nderlying	cause give	en in Part I.	23e. Did	tobacco us	e contribute to	the ca	ause of death?	
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Division of Vital Records, P.O.	The law rec te has bee page 2 sho	omplet								_	l perf	s an opsy formed?	24b. Were au prior to death? 1  Ye	comple	findings availabetion of cause o	le if
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ί	Physic this or	일	1  Yes 27. Manner of Deat	No	1 ∐ Inpati	ırv	ER/Outpatien	t 3 🗆 [	OOA Cther 28c. Injury	4 U Nursing I	Home 5 Res			cify)	_	
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Divis	oital or Aturs a er		4 🗌 Homicide	determined	28e. Place of Injury building, etc	c. (Specify,	)					wn, State)			nte Nurriber,	
	e Host n 24 ho e Fune	Medical	(Check 2	Medical Exami	sician: To the best of iner: On the basis of e se Practioner: To the	xamination	and/or invest	igation, in	n my opinior	n, death occurred	at the time, date	and place, a	and due to the	cause(s		ated.
	To the within comp	2	29b. Signature and			<b>1</b> 0			c. License		,		signed (Mont			
	1		30. Name and add	ess of person who	completed cause of c	leath (Item	23a) (Type, P	rint)		130 / j	~ 11 o		Buth	سارو		
	Ψ		SUSAr 31. Date filed (Mont		32. Registra	_		Wi	Jun	81×144	C, #2	<i>w</i>	m	0	20814	_
	Stat Registra		1111 90				ares									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23596 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 GEORGE ADAMS 5:30 PM Α 07 Medical 4a. Facility Name (if not institution, give street and number)

GOOD SAMARITAN HOSPITAL 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 1 2 🗆 F Months Days Hours Min. 81 **Director** 215-24-9401 2-1929 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits notified at Director 1X Yes 2 ☐ No MD Baltimore na 10e. Street and Number 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 1601 E. Belvedere Avenue 21239 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or itel Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) the Me Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant; If item 27 is marked other tha ury or other traumatic event, the I Railroad 8th grade Track Foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clinton Adams Clare Chambers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Adams-Son 1808 E. Belvedere Avenue Department of Healt Important: If item 2 any injury or other once. Balto, MD 21239 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Pk 7-30-2010 Randallstown, 22. Name and Address of Facility March East F/H ture of Funeral Service Licenses 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ RESMIRATORY FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** 3 DAYS PNUMONIA ASPIRATION Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: Examir DEMENTIA physician and the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Box 68760 38 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No ģ Day Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 X No death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical Division of Vital funeral director. 26. Place of Death (Check only one) examiner? Hospital Other: 2 🔀 No မ 1 Tyes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) e Hospital or Attending PP n 24 hours after death.

Pe Funeral Director: After the hole of filled in by the funers 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 only one) 29b. Signature and title of certifier namel har RESIDENT 29c. License number 29d. Date signed (Month, Day, Year) RES-000 07/24/2010 PHYSICIAN

Registrar

State

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. SAMEER CHAUDHARI, 5601 LOCH RAVEN BLVD, BALTIMORE, MD - 21239

			1 - For State Registrar	State of Ma	aryland / D	epartmer Certificat	it of H	leaith a	and M	ental Hygi	ene	P'0	23591
			Decedent's Name (First, Middle, La.	st)						2. Date of Death	1		3. Time of Death
	Physici /Medi		SHIRLE	Y AYR	RES					$\overset{ ext{Month}}{ ext{July}}$	Day 2 2	010	10:05A M
j	Examir		4a. Facility Name (If not institution, give			4b. City	Town, or	Location of	of Death		4c. County	of Death	
н			Glade Valley Nurs:	ing & Rehal	bilitati	on Wa	.1ker	svill	.e		Fre	deri	ck
	Funeral		Social Security Number     6. S	ex 7. Age	e (In yrs. last birtl	Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign ntry)
	Director		304-24-8538	UM ZIZIF	86 Y	rs.				July 21,			York
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
	Manyi f sho	ō	MD Fredre	ick	7,								1 ☐ Yes 2 🏝 No
	28e-	ect	10e, Street and Number			10f. Zij	Code			10	n Citizen of	What Cou	ntn/?
	with with	ā	6351 Spring Rid	an Plana #2	44		1701			10	_		
	Jeath True	Funeral Director	11. Marital Status	12. Was Decedent B				ispanic Ori	gin? (Spe	cify Yes or No-		e - Ameri	can Indian,
က	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28e-f show to Medical Examinar must be notified at	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔯 N					, Puerto F	cify Yes or No- Rican, etc.)	1		
ဇ္ဇ	el', o	ğ	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 🔀 No	Specify:			Specif	y: wn:	ıte
Maryland 21215-0036	72 ho natui	Completed	15. Decedent's Ec (Specify only highest gra	lucation	16a. I	Decedent's Usu	al Occupa	ation	t of working	1	Reg. No.  Reg. No.  Reg. No.  Ac. County of Dea Freder  Ac. County of Dea Biack, White County  Ac. County of What County  Ac. County of What County  Ac. County of Dea Biack, White County  Ac. County of What County  Ac. County of Dea Biack, White County  Ac. County	usiness/Ir	idustry unk
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Baltimore,	S = 0		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Removal from State	cemetery	Disposition (Nat , crematory or o	ne or other place	θ)	U	ate 2	Oc. Location	City or 1	own, State
Ë	permit, Page Department of Importent: If any injury of once.		'4 ☑ Donation 5 ☐ Other (Specify		7				Char	No. No. of the	1/		
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	40140		23a. Part1. Enter the disease, or comp		The death David					-		rial.	
			SHOCK, OF THEATT INTO LIST ONLY	one cause on each iin	θ.		-			respiratory arres	51,		Approximate Interval Between Onset and Death
F	Physician	37	Immediate Cause (Final disease or condition resulting in death)	a. Gal	blade	ler	Car	Yeing	ama				4 mlly
	/Medical Examiner		( )	Due to (or as a	a consequence of	):							
		*	Sequentially list conditions,	b. Due to (or as a	a consequence of	1.							
Т	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury	200 10 (01 03 1	2 CONSOQUONOC O	,.							
	be executed sicion and burial-transit	xar	that initiated events resulting in death) Last	c. Due to (or as a	consequence of	):						_	
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9	ficate physics the			0.									
ŏ	requires that the death certifica resistance of the attending ph hould be detached to reasett	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Da	te of deliv	erv
m	death	ciai	in the past 12 months?	1□Live birth 4□Pregnant at		3 ☐Ectopic po 5 ☐ Other (se							Day Year
0	t the	hys	9 □ Unknown	9□ Unknown									
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<u>8</u>	w require									1 ☐ Yes	2 1 No	3 🔲 Proi	oably 4 Unknown
Records,	aw re	Completed								24a. Was an	24b.	Were auto	opsy findings available
	The law ate has a	mo			···································					autopsy	ed?	death?	impletion of cause of
Vital		a	25. Was case referred to medical					26 Place	of Death	1 Yes 2			2L No
		0 8	examiner? 1 ☐ Yes 2 🖫 No	Hospital: 1 ☐ Inpatier	nt 2 ER/Outp	atient 3 DC	Othe					er (Speci	(v)
0	g Physer this	n: T	27. Manner of Death	28a. Date of Injury (Month, Day	y. 28b. Ti	me of 2	8c. Injury Work	at					,,
ō	Attending Fir death.	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		7007/ [[[]	ury M		.r ∕es 2 🔲 h	No				
DIVISION	of or Attend after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At home, farr	n, street, factor	, office	-1-20	2	8f. Location (Stre	et and Numb	er or Run	al Route Number,
ā	spitel or A	Cer		James 19, oto	. (Cpcony)					ony or rount,	Glato)		
	Hospitel		29a. Certifier 1 Certifying Ph	sician: To the best of	f my knowledge,	death occurred	at the tim	e, date and	d place, a	nd due to the car	se(s) and ma	anner as s	itated.
	9 9 9	Medical	one)	and manner star	led.	or investigation	, in my op	inion, deat	ii occuire	d at the time, dat	e and place,	and due t	
	To the To the	2	29b. Signature and title of certifier	2_		290	. License			29			
!							D43	3091			7-22	201	0
			30. Name and address of person who		ath (Item 23a) (T	ype, Print)	£A	/	1	- T	2 82	cl.	110 0 -
			Sound Carid		80 1	1011	D	our	- 7	me, 12	celes !	u ,	MD 21701
	Sta	-	31. Date filed (Month, Day, Year)	32. Pogistra	r's Signature								
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2010 23598 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ July 2010 3:00 A. M Marshall John Bruce, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Presbyterian Home Baltimore Towson 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 24 Hrs. Sex 1 X M 2 □ F **Funeral** Min. Hours Oct. 30, Year) Maryland 214-24-9578 89 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland | Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 400 Georgia Ct. 21204 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Force 1 X Never Married 2 Married þ Yes 2 X No 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Divorced White Completed 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 5+ years Assistant Head Master Boys Latin School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Marshall Bruce, Sr. Eliza Dancy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mportant: If item 27 Maryland 21057 Eliza Dancy Bruce Mills (Guardian) 11520 Manor Road Glen Arm, injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Crematory July 29,2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21. Signature of Funeral Service Licensee 21212 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ nehmon.9 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🗍 No Yes 2 N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Tes 2 🗌 No Accident
Suicide Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D. FOI P. Charles St, Set 4104 saffron 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Baltimore, Maryland 21215-0036

68760

Box (

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Banks Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Randallstown tarbnook Koad Baltimore 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 **X** F Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 2.1.A. Was Decedes... Armed Forces? Ves 2 No 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ğ 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygie is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ STOKES and 2 should be Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 INR MRUNING POWEI MD MAILSTOURS injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service licensee DERRICK C. JONES FH. P. A any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ BEEAST METASTATIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No ☐ Pregnant at time of death ☐ Unknown Day 1 Yes 2 7 9 Unknown ate has been signed by the a page 2 should be detached in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CARDION ASCULAR DISEASE 44DERTENSIVE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? Yes 2 No certificate To the Hospital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 Pending within 24 hours after death. To the Funeral Director: At 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 'Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Light Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D2807 willow) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amily Health Centers of Balt

Amily Health Centers of Balt

32. Resistar's Signature 631 Charry hillRoad Bulteron MAZIZZS State

DHMH 17 Rev 7/2009

Registrar

Box 68760

Division of Vital

State of Maryland / Department of Health and Mental Hygien 2010 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2304 July 2010 25 HENRY E. BURNETT /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner DE GRACE HARFORD MEMORIAL HOSPITAL HARFORD CO Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Year) 1**X** M 2□ F Months Days Hours 49 Yrs Director NOV. 9 1960 **GERMANY** 217-64-1329 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo MARYLAND HARFORD CO ABERDEEN 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number by Funeral 438 HOLLY DRIVE 21001-3438 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □Yes 2X No If Yes, Give Year or Dates: Specify: Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) CARPENTER PRIVATE 12yrs lvrs 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Mental pe permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic ev FRANCES BURNETT HAROLD L. BURNETT ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Frances L. Burnett/Mother 438 Holly Dr., Aberdeen, Maryland 21001 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07-31-10 ABERDEEN, MARYLAND CALVARY CHURCH_ 21. Signature of Funeral Service Licens 22. Name and Address of Facility
WILLIAM C BROWN COMM FUNERAL HOME-HARFORD 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 Par 1. Enter the disease or complications that caused the shock, or heart failure. List only one cause on each line r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) SHOCK SEPTIC **Physician** /Medical Due to (or as a consequence of). Examiner EMPYEMA SEUDOMONAS Sequentially list conditions, if any, leauing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-tran Due to (or as a consequence of) Physician/Medical for use as Box IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Ö detached 9 Unknown that the 9 Unknown σ, 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Records, law requires page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Attending Physician: The 2 12 No 1 ☐ Yes 2 ☐ No Vital After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient Division of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide ō the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completely (Check only and manner stated. within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0069118 A MD 50,
32. Registrar's Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501 S. UNION AVE HAVRE de GRACE, MD 21078 PuthA KHALID WALA 31. Date filed (Month, Day, State 2920 Registrar

State of Maryland / Department of Health and Mental Hygiene 23601 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JUMOnth YAKOV 2010 BRISK 9:20A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TOWSON
If Under 1 Year I If Under 24 Hrs. GILCHRIST HOSPICE CARE RALT IMORE 8. Date of Birth (Month, Day, Year) 09/02/1937 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Hours 1 X M 2 □ F UKRATNE 214-90-3936 Director 72 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2**\(\)**No BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 774 KENNINGTON ROAD 21136 USA 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) DRIVER CABS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ EVA RUVIN BRISK UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LUDA TEETER/DAUGHTER 809 CHAMPIONS COURT, REISTERSTOWN, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State BETH EL MEM PARK 1 № Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 07/25/2010 RANDALLSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Sign fure of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on Lause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate bases. Enter underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: fyes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 1 Yes 2 L 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires i within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2 X No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 🗌 Yes 2 🔽 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🔲 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) in 24 hous,
o the Funeral Decompleted filler Medical 29a. Certifier 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 100070635 PATED 7/22/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21202 Patel 2 Charles 31. Date filed (Month, Day, Year) 32. Registrar's Signatur 29201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 23602 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month (50:29 N David Busch July 24, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Worcester Berlin Social Security Number 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, **Funeral** 9. Birthplace (State or Foreign 1 ፟M 2 □ F Months Days Hours Min Director 219-30-4119 Yrs Usual Residence of Decedent shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f s Md. Anne Arundel Pasadena 1 Tes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8347 Fairwood Dr. 21122 USA items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☒ Yes 2 ☐ No Black, White, etc. ō Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Tes 2X No Specify. "natural", White 3 Widowed 4 Divorced Specify. Year or Dates event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha 12 Inspector, Quality Control Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Emi 1 Busch Ethel injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret M. Busch (Spouse) 8347 Fairwood Dr. Pasadena, Md. 21122 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🛛 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Meadowridge Cemetery 7-27-10 Elkridge, Maryland Signature f Funeral S 22. Name and Address of Facility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one car that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate on each line Interval Between Immediate Cause (Final Onset and Death Ph sician/ SCV2 disease or condition resulting in death) YICS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Year Pregnant at time of death Month Day g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an certificate has I autopsy perform death? Yes 2 🗀 No Yes 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No completed filled in by the funeral director, ion of Vital Be 26. Place of Death (Check only one) Hospital: Other: ္ဝ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 🗌 Yes 2 🗌 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier 🛄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 To the I only one) 29b. Signature and title of certifier 29c. License number of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address State 32. Re Registrar

TOD: 0030

State of Maryland / Department of Health and Mental Hygiens 23603 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 4:07p Geraldine Coates Jul 19, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Glen Burnie **Baltimore Washington Hospital Center** If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Director 217-24-1286 Jan 24, 1930 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 28a-f show 10d. Inside City Limits ns 23a or 28a-f sh must be notified Director 1 XYes 2 □ No Anne Arundel Pasadena Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 7847 East Shore 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 □Yes 2□No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner 7 Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 9 1 ☐ Yes 2 ☐ No Specify 3 ☐ Widowed 4 ☐ Divorced Specify. Black 'natural' Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. College (1-4or 5+) Sears Company The same Sales Clerk other 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ?7 is marked c traumatic ever Edith B. Boone Benjamin Boone Sr. ပ Health and New 27 is mai 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7847 East Shore Pasadena, Maryland 21122 permit. Pages 1 and Department of Health Important: If item 27 any injury or other tonce. other i Robert Coates 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/26/10 Pasadena, Md. Mt. Zion Church Cemetery of Frieral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 21217 ode of dying, such as cardiac or respiratory arrest, 23a. Pan 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode Immediate Cause (Final disease or condition resulting in death) Physician myocardia /Medical Du to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be execut burial-tra Due to (or as a consequence of): attending physician Physician/Medical the as use yes, outcome of pregnancy

☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? Month Day Yea 5 Other (specify) P.O. ☐Yes 2☐No ed by the 9 Unknown signed be det Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ hknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate performe Division of Vital 1 □Yes 2 🗆 No 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 patient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural
2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death Director: filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ca (Check only one) 29b. Signature and title of certifie 0 29c. License number 29d. Date signed (Month, Day, Year) Glen Burnie, MD 21061 completed cause of death (Item 23a) (Type, Print) MOS 31. Date filed (Month Dav. Year) State 29 Registrar

10-05608 Matthew Brian C			epartment c	of Health and			161e. 20 I	0 23604
		Registrar	Certificate o	of Death			. No.	
Physicia Medical Exami	an <i>l</i> ner	1. Decedent's Name (First, Middle,Last)  Matthew Brian Clarke				2. Date of Death Month July 27, 20	Day Year 10	3. Time of Death 0030 hrs
		4a. Facility Name (if not institution, give street and number) 6636 Washington Blvd #42		4b. City, Town, or L Elkridge	ocation of Death		4c. County of [ Howard	
Funeral		•	rs. last birthday)	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.			<ol><li>Birthplace (State or Foreign Country)</li></ol>
Director		218-23-2942	) Yr			06/03/1	980	Maryland
Any			City, Town or Loca	ition				10d. Inside City Limits
land f show	ō	Maryland Howard	E1kr					1 Yes 2 X No
e Mary	Director	10e. Street and Number 6636 Washington Blvd. #42		10f. Zip Code 21075			g. Citizen of What Inited St	
r death with the Maryland or items 23a or 28a-f show must be notified at once.	न्त	11. Marital Status 12. Was Decedent Ever i	in U.S. 13. W	as Decedent of Hisp				American Indian, Black,
death or item must b	Fune	1 Never Married 2 Married Armed Forces? 1 Yes 2 X N		Yes, specify Cuban,		Rican, etc.)	White, e	•
s after	۵	Widowed 4 Divorced If Yes, Give Year or Dates:     Decedent's Education (Specify only highest grade completed.	1 163 Decede	Yes 2X No		ork done	Specify: W	
72 hour	eted	Elementary/Secondary (0-12) College (1-4 or 5+)		nost of working life. [			Tob. Taria of Bacin	
5-0036 led within 7 Hygiene. I other than	Completed	12	Truc	k Mechani		yı =		notive
215-( be filed v ntal Hygi rked oth	Be Cc	17. Father's Name (First, Middle, Last)  George M. Clarke		18	3.Mother's Name Bonnie		aiden Surname)	
212 ould be ould be I Ment is mark	임	19a. Informant's Name/Relationship (Type, Print )	19b. Maifir	ng Address (Street			er, City or Town,	State, Zip Code)
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.		George M. Clarke  20a. Method of Disposition   20		Washingto		#42, E1k	ridge, M	
Baltimore, permit. Pages I an Department of He Important: If ite		1 Burial 2 X Cremation 3 Removal from State	crematory or o	ther place)				
ultimit. Paratmen artmen ortant	-	4 Donation 5 Other Specify:  21. Signature of Funeral Service License Aman a Reas	ston Crei	matory, Ind	of Facili@rema	8/2010 pation So	Baltimor	e, Maryland Maryland,Inc.
Dep Dem		Au bull	29	9 Frederio	ck Road,	Baltimo	ore, Mar	yland 21228
Physician Madiad		<ol> <li>Part I. Enter the disease, or complications that caused the defailure. List only one cause on each line.</li> </ol>		the mode of dying, s	uch as cardiac or	respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
Examiner	İ	Immediate Cause (Final disease or condition resulting in death)  Intra-Oral Shotgun V  Due to (or as a consequence)						Death
~ /		Sequentially list conditions, b.						
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	ce of);					
msit ed	Exal	events resulting in death) Last Due to (or as a consequence	ce of):					
e executed cian and rial - transit	dical	UNPENDED AMENDED			-			
Box 68760, e death certificate be the attending physicited for use as the buring for the buring for use as the	cian/Med	IF FEMALE: 23c. If yes, outcome of p			Ectopic pregnar		23d. Date of de	
x 68 th certif	iciar	past 12 months?  4 Pregnant at time o		etal death 3 L	_Ectopic pregnar	icy	Month	Day Year
Bo he deat y the at the for	Physi	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but n	not resulting in the	underlying cause cit	en in Part I	23e Did toh	acco use contribu	te to the cause of death?
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	٥	Contributing to doubt but in	or resuming in the	andonying oddoc gri		1A -	2 🗸 No 3	
Division of Vital Records, ral or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should the	Completed					24a. Was ar autops	y prio	re autopsy findings available or to completion of cause of
Rec The la	S					perform 1 Yes 2		Yes 2 No
/ital sician: is certi	a	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	ER/Outpatien		of Death (Check of Death (Chec		esidence 6	Other: Scene
of \ng Phy	년 일	1 ✓ Yes 2 No Impatient 2  27. Manner of Death 1 Natural 5 Pecalina FOUND:  1 Ves 2 No Impatient 2  28a. Date of Injury FOUND:  1 Decading 1	28b. Time of		at Work?		w injury occurred	
Sion Attendideath.	atio	2 Accident Investigation Jul 27, 2010	FOUND: 0028 hrs		es 2 V No			
Divis	ertification:	3 ✓ Suicide 6 Could not be determined (Specify) Mobile I		eet, factory, office bui			reet and Number ( ite) on Blvd #42, Ell	or Rural Route Number, City  kridge, MD
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	ပ	29a. Certifier 1 Certifying Physician: To the best of my know	vledge, death occu		e and place, and	due to the cause	(s) and manner as	s stated.
To th within To th	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated.  29b. Signature and title of certifier	on and/or investiga	29c. License				(Month, Day, Year)
			. /	O.C.M			July 27, 2010	
A	}	30. Name and address of person who completed cause of death (I						
	nte	Jack Mtus MD. Deputy Chief Medical Exami  31. Date filed (Month, Day, Year)  32. Registrar's Sign	in other co	nn Street, Baltir	more, MD 21:	201		
Regist		11 29 2010 Jene S. A	Carper					

State of Maryland / Department of Health and Mental Hygien 23605 Certificate of Death Reg. No. 2. Date of Death Physician/ Month OHDA 2010 Medical ility Name (if not institution, give stree Town, or Location of Death 4c. County of Death **Examiner** timpi 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Director 28a-f show 10a. State 10d. Inside City Limits notified at 10c. City, Town or Location Director 1 Res 2 No timore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 9 permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a giving or other traumatic event, the Medical Examiner must be a Funeral Ker 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Never Married 2 Married ò 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ife. DO NOT use retired) College (1-4 or 5+) Be Maiden Surname Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur A Fun ral Se, ce Licensee no 2121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Sepsi Sèvere Ph_sician/ disease or condition resulting in death) ) Medical Due to (or as a consequence of) Examiner Preumonia Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for Pregnant at time of death signed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mmunodesiciency Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No certificate ! 1 Yes 2 No director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No ဂ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending work? 1 ☐ Yes 2 ☐ No 1 Matural injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29c. License number emccl RES-00 MENUCCI, MD 25 2010 MARIA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MENUCCI Blvd-Baltimore. MD- 21239 Le Registrarie State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

	State of Maryland / Department of Health and Mental Hygiene									
			Registrar	Certificate of Death				2010	23606	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		A	Mo	te of Death onth D	ay Year	3. Time of Death	
	Medic		4a. Facility Name (if not institution, give street and number)	07	4b. City, Town, or Location of		LY 2		10:45 A M	
	Examin	er	1829 North Wolfe Street		BALTIMURE		213	BALTI M		
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last	t birthday)	If Under 1 Year If Under	24 Hrs. 8. Dat	e of Birth	9. Birth	place (State or Foreign	
	Director		224-38-0405 1 M 2 X X 81	Yrs.	Months Days Hours	Min. (Mo	1-10-1	.928 ^{Cour}	N.C.	
	d low It	_	Usual Residence of Decedent  10a. State 10b. County 10c. City.	Town or Loc	ation					
	arylan a-f sh fied a	Director	100. 01.9,	ltimo					10d. Inside City Limits 1   Yes 2 □ No	
	or 28		10e. Street and Number		10f. Zip Code		100.0	itizen of What Cou		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important if fire Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	əral	1829 N. Wolfe Street		2121	3	_	JSA	illi y :	
		Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. W			or No-	14. Race - Americ	can Indian,	
9	fter d ", or i amin		1 ☐ Never Married 2 ☐ Married Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give	<ul> <li>33. Was Decedent of Hispanic Origin? (Specify Yes or Not If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> <li>1 ☐ Yes 2 ※ No Specify:</li> </ul>			etc.)	Didok, White, etc.		
ğ	ours a tural	Completed by	Year or Dates.					Specify: B	Lack	
<del>1</del>	72 hc n "na ledic	nple	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)				16b. I	Kind of Business In	dustry	
72	/ithin iene. rr thai	ပ္ပြဲ	Elementary/Seconday (0-12) College (1-4 or 5+)		ook		N	Jursing	Home	
0	be filed v ental Hyg rked othe ic event,	To Be	17. Father's Name (First, Middle, Last)			er's Name (First, i				
/lar	d be f Venta arked stic e		Onin Davis		Eth	el Jon	es			
lan	should and N is ma				g Address (Street and Numbe					
≥.	and 2 should be fil Health and Mental em 27 is marked o ther traumatic ev		Wallace Cozart-Husband	182	9 N. Wolfe	Street	Balto	, MD 21	213	
_	Je 1a It of H If ite or ott		1 🗶 Burial 2 □ Cremation 3 □ Removal from State   cen	netery, crem	ition (Name of atory or other place)	Date	1	ocation - City or To		
Ę.	permit. Page Department o Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) King					dallst		
Ba	permit. Departr Importa any inju		21. Signature of Funeyal Service Licensee		Name and Address of Facility 101 E. Nort			Cast F/H		
			23a. Part 1. Enter the disease, or complications that caused the death.					.co/ Hb	Approximate	
P	nysician/		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	. = -	-0000 VASION	AD A	- 1 N 5 1	-	Interval Between Onset and Death	
	Medical		Immediate Cause (Final disease or condition resulting in death)  Onset and Death  Onset and Death  Onset and Death							
	Examiner	L	Sequentially list conditions					- 33		
Sequentially list conditions, if any, leading to himeulate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  Due to (or as a consequence or):  Due to (or as a consequence or):									·-	
D.	and -trans	Cause (Disease or linjury that initiated events culting in death) Last Due to (or as a consequence of):								
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760	cate phys s the	ledic	d		-					
687	nding use a	N/	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy					23d. Date of deliv	erv	
in the past 12 montbs?    Live Birth 2   Fetal death 3   Ectopic pregnancy								Month	Day Year	
		ٳڴ۪ٳ	9 Unknown							
0	gnec gnec	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did to					bbacco use contribute to the cause of death?		
g Q	equire sen si ould l	ted					1 Yes 2 No 3 Probably 4 donknown			
<u></u>	law re	Completed				248	a. Was an autopsy	prior to co	psy findings available impletion of cause of	
۳ پ	isician: The law s certificate has k lirector, page 2 s					1 [	performed?  Yes 2	o death?	2 🗆 No	
<u> </u>	cector,	a l	25. Was case referred to medical examiner? Hospital:		26. Place of Deat	th (Check only on	ne)			
<u>}</u>	rnys ral dir	٩	1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Presidence 6 Other (Specify)						)	
ם ב	th. After	Certificate:	1 Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation	injury	28c. Injury at work?  M 1 1 Yes 2		scribe how inju	y occurred		
Division of Vital Records,	r dea	ŧ	3 Suicide 6 Could not be 28e. Place of Injury - At home	e, farm, stre		_	ation (Street an	nd Number or Rurai	l Route Number	
<u>&gt;</u>	s afte	ဒီ	building, etc. (Specify)	City or Tow						
-	or the robspire or Autenting Prysicians: within 24 hours after death. To the Funeral Directors After this certific completed filled in by the funeral director,	dica	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	the Fi	Medical	(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying furse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	2 with 2		29b. Signature and title of certifier		29c. License number		29d. Da	te signed (Month,	Day, Year)	
	カ		M.D		D57722		JU	LY 28	2010	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								815-1015 110 315 511		
	Stat	State 31. Date filed (Month, Day, Year) 32. Registray's Signature								
	Registra	-	31. Date filed (Month, Day, Year)  32. Registrar's Signature  31. Date filed (Month, Day, Year)	ale						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 23607 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month CLAY, JR. 22:36 M CRAWFORD Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death of Baltingre Hospital Baltimon Funeral 8. Date of Birth Birthplace (State or Foreign Country) 1 X M 2 D F Months Hours Min Director 215-34-8482 Usual Residence of Decedent Department of Health and Mental Hygiene. Incurs and terms 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits RANDALLSTOWN 1 Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3937 CHAFFEY ROAD 21133 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify. Year or Dates WHITE 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) INDUSTRIAL ENGINEER ENGINEERING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CLAY, SR. MILDRED **ROEHNER** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3937 CHAFFEY ROAD, RANDALLSTOWN, MD 21133 ETTA CLAY/WIFE 20a. Method of Disposition 20b Mage of Disposition (Home of DE) Date 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODMOOR HEBREW CEM. 7/27/2010 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mall 8900 REISTERSTOWN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, disease or condition resulting in death) days Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I any course in the Underlying Cause (Disease or linjury Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Year Pregnant at time of death Day been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? obstructive pulmonary disease, 1  $\square$  Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an type coronan avery disease has e 2 s autopsy perform Chronic certificate rena Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Tes 2 No after death Director: / d in by the f Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after

To the Funeral Dire

completed filled in b Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatura 00 C as 2010 and address of person who completed cause of death (Item 23a) (Type, Print) Hospital of Baltimore, 2401 N. Belvedere Ave, Baltimore Jessica Hobbs, U.D. MD ZIZIS

DHMH 17 Rev 7/2009

State Registrar 32. Registr

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State of Maryland / Department of Health and Mental Hygiene

			1 - State of Marylands State of Marylands State		artment of F tificate of L			2010	23608	
П	Physicia		Decedent's Name (First, Middle, Last)  SOL P. CAPLAN				2. Date of Dear	Dav Year	3. Time of Death	
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	r Location of Death	<u>I JULY</u>	25 2010 4c. County of Death	1:15 P M	
	Funeral		7006 FIELDCREST ROAD  5. Social Security Number   6. Sex   7. Age (In ye							
	Director		220-18-3868 1XXM 2   F   85							
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Detentment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits							
			MD N/A  10e. Street and Number	BALT IM	ORE 10f. Zip Code				1 X Yes 2 □ No	
			7006 FIELDCREST ROAD		Toil. Zip Code	21215		10g. Citizen of What Cou USA	ntry?	
Maryland 21215-0036			11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  12. Was Decedent Ever in Armed Forces?  14. ☑ Yes 2 □ No lift Yes, Give Year or Dates.	1	Vas Decedent of Hi Yes, specify Cuba		pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify: WH		
15-(	72 hou		15. Decedent's Education (Specify only highest grade completed)	(Give k	lent's Usual Occupa kind of work done of O NOT use retired)	ation during most of wor	king	16b. Kind of Business In	dustry	
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land	should be filed and Mental H is marked of raumatic even		17. Father's Name (First, Middle, Last)  BENJAMIN  CAPLAN			18. Mother's Nar ROSE	ne (First, Middle, N EDE	Maiden Surname) LSON		
Mary			19a. Informant's Name/Relationship (Type, Print) HARRIET B. CAPLAN/WIFE					City or Town, State, Zip	Code)	
re, l	1 and 2 of Healt item 2		20a. Method of Disposition 20th	b. Place of Dispos	-			RE, MD 21215	own, State	
Baltimore,	it. Page rtment rtant: It rjury or			AI ISRAE	L CEMETE	RY 07/27		BALTIMORE,		
Ba	Der a lmp o any i	N.	21. Si netu) of Funeral Service Incensee	89	Name and Addres REIST	ERSTOWN	LEVINSO ROAD, PI	N & BROS., KESVILLE, M	INC. D 2 <b>1</b> 208	
ل	h sician/ Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each like.  Approximate Interval Between							
			Immediate Cause (Final disease or condition resulting in death)  Onset and Death  Onset and Death  Onset and Death							
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  b. Boucyon's 2º Boon order to Lwon by Open Constitution of the Consti							
									0	icate be executed g physician and s the burial-transit
	tificate ng phy as the	by Physician/Medical							IF FEMALE:	
Вох	v requires that the death certifications is been signed by the attending should be detached for use as		23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   A   9   Unknown   1   Unknown   23c. If yes, outcome of pregnancy   1   Live Birth   2   Fetal death   3   Ectopic pregnancy   1   Live Birth   2   Fetal death   5   Other (specify)   Month   Day   Year   Year   Yes   Year   Yes   Year   Yes   Year   Yes   Year   Yes   Year   Yes   Year							
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ords	v requir	oletec	1   Yes 2   No 3   Probably 4   Unknown    * White State   24a. Was an   24b. Were autopsy findings available							
å.	ate l page	Completed by	autopsy performed?  1 \( \subseteq  Yes 2 \( \subseteq \) No \( \subseteq \) \( \supseteq \) \( \subseteq \) \( \supseteq \) \( \supseteq \) \( \supseteq \) \( \supsete							
ıtal :	sician; s certifi lirector	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2	□ FB/0. 44	Othe	r:				
n of	I or Attending Phy after death. Director, After this I in by the funeral c		27. Manner of Death    Natural   5   Pending   2   Accident   Investigation   A   Accident   Investigation   Accident   Accident   Investigation   Accident						)	
Division of Vital Records,		Medical Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spec	home, farm, stree	m, street, factory, office 28f. Location (			Street and Number or Rural Route Number, wn, State)		
<b>-</b>			29a. Certifier (Check only one)  1							
			29b. Signature and title of certifier MD.		29c. License			9d. Date signed (Month, I		
	101		30. Name and address orberson who completed cause of death (Item 23a) (Type, Print)  DINO PATEL 555. 19, MALKER BYE SMK: 202 PIKESYINE - 555 21208.							
	State Registra	-	31. Date filed (Month, Day, Year)  32. Registrar's Sign			- 402.	11/2011410	- 4315	,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 3 per doc, 16b per fh g906 8-2-10 vt.

State of Maryland / Department of Health and Mental Hygien 0

23609 State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Ye aı M **Yvonne Cornish-Marlowe** 9:50a p Jul 21, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A **Baltimore** 302 Midland Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 □ M 2 □ F **Director** 216-44-5248 Nov 22, 1944 Maryland Usual Residence of Decedent with the Maryland 10a State 10b County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 □XYes 2 □ No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 302 Midland Avenue 21225 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No \$ Specify: Specify 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) **CBY** Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) **GDY** Enterprises Owner 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Smith Minnie L. Smith traumatic ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a
Important; If item 27 is
any injury or other trae Tonia L. Bowie 302 Midland Avenue Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 1 DeBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 07/30/10 Brooklyn Park, Md. Cedar Hill Cemetery & Mausoleum 21. Signature of Funeral Service 22. Name and Address of Facility Estep Brothers Funeral Service, P. A.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory and a limit of the disease of the death. Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** tole rend disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Breit Sequentially list conditions. ne rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examir Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): burial Box 68760, physician Physician/Medical the as attending for use as IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 5 Other (specify) P.0. the 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 9 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy certificate perform Division of Vital 2 100 1 □Yes 2 ZINO 1 ☐ Yes funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2. □No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Natural 5 ☐ Pending in 24 hours after death.

Reference of the following the following in by the following death. 2 Accident investigation 1 ☐ Yes 2  $\square$  No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 the 29b. Signature and title of certifier, Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Antoinette Dabney Medical 4a. Facility Name (if not institution, give street and number **Examiner** City, Town, or Location of Death 4c. County of Death mayland Greneral | If Under 1 Year | If Under 24 Hrs. | 8. Unter of Birth | Months | Days | Hours | Min. | Aug | 6 , 1935 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Mary Land Director Yrs 74 216-26-7560 Usual Residence of Decedent show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD 1 X Yes 2 No Baltimore 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 3939 Penhurst Avenue 21215 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mus once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑XNo If Yes, Give Year or Dates. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married white 1 Yes 2 No Specify 3 K Widowed 4 Divorced Completed Specify. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Rusiness Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk homemaker own home Be 17. Father's Name (First, Middle, Last). unk 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mamie Rossi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gina Nine - niece 874 Mildred Avenue; Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 🗶 Other (Specify) in state ature of Euneral Service Ronal d 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, beart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of) Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Day 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hosp 2 X No မ 1 Yes funeral Manner of Death 1 Natural 5 Pending

and attending physician for use as the burial Records, P.O. Box 68760 by the has certificate **Division of Vital** Hospital or Attending Physician: this After n 24 hours after death.

Ne Funeral Director; Af pleted filled in by the fu

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Certificate: Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

tal: 1 Inpatient 2 🗆	ER/Outpatient 3	B 🗆 DOA	Other: 4	☐ Nursing H	ome 5 Residence 6 Other (Specify)
8a. Date of injury (Month, Day, Year)	28b. Time of injury		Injury at work? 1  Yes	2 🗆 No	28d. Describe how injury occurred
Be. Place of Injury - At ho		factory, of	fice		28f. Location (Street and Number or Rural Route Number,

Tanania, etc. (2,2501)/	City or Town, State)
an: To the best of my knowledge, death occured at the time, date and	d place, and due to the cause(s) and manner as stated.
r: On the basis of examination and/or investigation, in my opinion, death of	occurred at the time, date and place, and due to the cause(s) and manner state
Description of the first of the state of the	

9a. Certifier (Check only one 3 Certifying Physician: To the best of my knowledge, death occur only one 3 Certifying Nurse Practionur: Lithing and only one only one of the basis of examination and/or investigation.	<ul> <li>in my opinion, death occurred at the time, date</li> </ul>	and place, and due to the cause(s) and manner state
9b. Signature and title of certified	29c. License number $897.22$	29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type Creetha Somash-Kar, M.D. 40 31. Date filed (Month, Day, Year)

State Registrar

completed within 2

Medical

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Date of Death
 Month . Decedent's Name (First, Middle, Last) Day Year **Physician** 7:26 DUDINE 2010 iene /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** NIA Secours Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) May 5, 1964 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours Maryland 1⊠M 2□ F 46 217-78-7887 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10b. County ral", or Items 23a or 28a-f show Examiner nast be notified at 10a. State TX Yes 2 □ No Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21213 USA 730 Ashburton Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Ye ar or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: black 1 ☐ Yes 2 No Specify. ۾ 3 Widowed 4 Divorced "natural" er than "nature the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) painter & landscaper home improvement is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maurice Dupree Sr. Jessie Cole 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jessie Dupree - mother 2900 Boarman Avenue; Baltimore, Maryland 21215 Department of Health Important; If item 27 any Injury or other to once. 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4□Donation 5♥ Other (Specify) in state Roma C 22. Name and Address of Facility State Anatomy Board Wade 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) week Hepatic **Physician** Fulminant /Medical Due to (or as a consequence of): Examiner stage liver Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as sequence of) Hospital or Attending Physician: The law requires that the death certificate be executed -lepatitis burial-trar Due to (or as a consequence of): physician s the burial P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ş Rena disease 2**X** No End 3 Probably 4 Unknown 1 Tyes certificate has been s rector, page 2 should Completed AIDS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No I X Inpatient 2 ER/Outpatient 3 DOA မ funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000 Baltimore 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

			State of Maryland				nd Me	ntal Hygi	ene 201	n	2361	2
			Registrar  1. Decedent's Name (First, Middle, Last)	Cer	tificate of D	Jealn 	2	. Date of Death	g. Ive		3. Time of Dea	
£	* Physicia Medic		Stanton	Day				Month Ju	ıl 23, 2010	Year	7:10a	М
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#E	Funeral		Mariner Health Catonsville-Summit Park Rel 5. Social Security Number 6. Sex 7. Age (In yrs. last t		If Under 1 Year	If Under 24		. Date of Birth		9. Birth	place (State or For	reign
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	and show Lat	or	Usual Residence of Decedent  10a. State 10b. County 10c. City, To	own or Loc	ation						Od. Inside City Lir	mits
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	ith the 23a or st be n		10e. Street and Number 3102 Leeds Street		10f. Zip Code	21229		11	0g. Citizen of W	hat Cour	•	
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<u>im</u>	Page Tent o ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		atory or other place in Park Ceme		08	3/02/10	Ba	ltimore	e, Md.	
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<u>\</u>	r this caral dir	e: To	1 Inpatient 2 ER/ 27. Manner of Death 28a. Date of injury 28b	b. Time of	28c. Injury	4 Nursir			nce 6 Other		)	_
on	ending eath. or: Afte he fun	ficat	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation 3 Suicide 6 Could not be	injury	M 1 □	? Yes 2 🗆 No						
Division of Vital Records,	I or Attend after death Director: /	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stree	et, factory, office		28f	Location (Street). City or Town,	eet and Number State)	or Rural	Route Number,	
Δ	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check 2 Medical Examiner: On the basis of examination and	d/or investi	gation, in my opinio	n, death occur	red at the	time, date and	place, and due	to the car	use(s) and manner:	stated.
	To the within: To the соттріє	Σ	only one) 3 Certifying Nurse Practioner: To the best of my knot 29b. Signature and title of certifier	owledge, de	eath occurred at the 29c. License	time, date and	d place, a	and due to the o	ause(s) and mar	ner as st	ated.	
			M.O.		2006	5861			7/23/10			
_			30. Name and address of person who completed cause of death (Item 23a		•	Y RD	BA	HTIMO	PF. M	19	21227	
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature									
			0.0000	19 1	MAKE							

10-05570 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 State of Maryland / Department of Health and Mental Hygiene Queonna Zophia Edmonds 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day July 25, 2010 1615 hrs Medical Examiner ZOPHIA **EDMONDS QUEONNA** 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore University Hospital N/A 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign VIRGINIA Months Days Hours Director 07/13/1985 Country) 1 M 2 X F 25 Yrs 224-37-4148 Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. Count 10c. City, Town or Location 1 Yes 2 X No e notified at once. VIRGINIA MECKLENBURG SOUTH HILL hours after death with the Maryland 10g. Citizen of What Country? 10e, Street and Number 101 ARROW WOOD LANE 23970 U.S.A Funeral 12. Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No 1 Yes 4 Divorced If Yes, Give Year Yes 2 X No specify: Specify: BLACK è 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 intent of Health and Mental Hygiene.
ant: If item 27 is marked other than "
or other traumatic event, the Medical Is 5-0036 ASST DIR OF SLAES AND SERVICE\$ PERFORMING ARTS CNTI 2th grade 4yrs 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROBERT EDMONDS OUEEN MORGAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) QUEEN MORGAN EDMONDS/Mother Hill Virginia Arrow Wood Lane, South 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date timore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Edmonds Family Cemetery07-31-10 SOUTH HILL, VIRGINIA 4 Donation 5 Other Specify. 22. Name and Address of Facility 21 Sonature of Funeral Service Licensee WILLIAM C BROWN COMMUNITY FUNERAL 1206 W NORTH AVENUE, BALTIMORE, MD Part I. Enter the disc e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only on cause on each line Between Onset and Micritical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last /sician/Medical g physician a UNPENDED AMENDED 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the attending p 2 Fetal death 1 Live birth 3 Ectopic pregnancy Month Year Day past 12 months? Pregnant at time of death Box 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown 무 detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o signed be deta ģ 1 Yes 2 No 3 Probably 4 Unknown σ. Completed Records, 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of has page 2 s death? performed? 2 No ✓ Yes 2 No certificate 1 🗸 Yes 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Vital Be examiner? Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other this 1 V Yes 2 No ð 28a. Date of Injury Jul 25, 2010 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Subject driver of auto struck by second auto Division 1519 hrs Natural 1 Yes 2 V No 5 Pending the that was fleeing police Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) 300 South Monroe Street, Baltimore, MD To the Hospital of within 24 hours at To the Funeral Ecompletely filled determined 4 V Homicide (Specify) Local Street 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

\( \) State

Registrar

292010 /lenewil

**OCME** 

Melissa Brassell, MD

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

July 27, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 70/0 **Physician** 6 /Medical 4c. County of Death (If not institution, give street and number) 4a. Facility Name **Examiner** andall timore +01 CP470 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 5. Social Security Number MD Country) Funeral Hours Yel 939 Months Days 1**√**M 2□ F 71 216-36-8313 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 1 □Yes XXNo Director MD **BALTIMORE** OWINGS MILLS 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21117 USA 34 MERRIAM COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give X 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2**X**No Specify Specify: WHITE è 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) **JANITORIAL** LABORER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **JACOB EPSTEIN** BERTHA LICHTENSHEIN ္က 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 113 NORTHWAY RD; REISTERSTOWN, MD 21136 HYMAN FRANKLIN / FRIEND 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) MY Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH JACOB ANSHE VESHEAR 7/2010 ROSEDALE, MD Signature of Juneral Service Licensee SOL LEVINSON & BROS., INC. B900 REISTERSTOWN RD; PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** 9. /Medical Due to (or as a consequence of) Examiner eumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? for 3 Ectopic pregnancy Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ☐Yes 2☐No P.0. this certificate has been signed by the al director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐Yes 2 ☐No 2 No 1 □Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, 27. Manger of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred spital or Attending Phours after death.
neral Director: After ty filled in by the funera Natural
Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certifie, 1053850 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 Len 4 west 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23615 Certificate of Death Reg. N 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:45 P " FINE ARNOLD JIII Y 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X**□ M 2 □ F Min 05/27/1 **Director** <u> 213-32-6925</u> Usual Residence of Decedent 10d. Inside City Limits than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 No REISTERSTOWN MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral USA 21136 300 SALONY DRIVE, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1) Yes 2 No
If Yes, Give Black, White, etc Completed by 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☑ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) SIGN SHOP OWNER Be or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ GOLDIE FINE **HARRY** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 OWINGS MILLS, MD 21117 Health tem 27 257 CEDARMERE CIRCLE MICHAEL FINE / SON permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of X Burial 2 Cremation 3 Removal from State VETERANS CEMETERY 07/26/2010 OWINGS MILLS, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Licensee PIKESVILLE, MD 21208 8900 REISTERSTOWN ROAD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on & ch line Immediate Cause (Final Physician/ respusting disease or condition Medical resulting in death) as a consequence. fi **Examiner** Sequentially list conditions Examine as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury recember as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: signed by the attendir I be detached for use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Month 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 death? 1 Tes To the Hospital or Attending Physician: To within 24 hours after death,

To the Funeral Director: After this certifica 26. Place of Death (Check only one, completed filled in by the funeral director, 25. Was case referred to medical **Division of Vital** examiner? Other: 4 Nursing Home 5 Residence 2 JHO ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Medical Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Signature and title 29c. License number 2010 person who completed cause of death (Item 23a) (Type, Print) 2835 PARTITIONE, KAKEN W. WENNITT SHITH 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Michael Lee Fador Julv 2010 3:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Baltimore 5718 Magie Street If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Min. 57 212 60 0548 Pennsylvania 11/20/1952 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State "natural", or items 23a or 28a-f show 1 □Yes 2 No Director Baltimore Anne Arundel Marvland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21225 5718 Magie Street Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 🌣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔣 No Specify <u>ک</u> Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event. It at the temportant is the property or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) A.A. Co. Public Schools Maintenance Supervisor 2 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Janet Daugherty Lee Fador 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21225 5718 Magie Street Vicki_Fador / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/29/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 xomerole Me 23 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** years disease or condition resulting in death) /Medical Due to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 2 No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 : autopsy performed certificate 1 ☐Yes 2 ☐No 1 ☐Yes 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After or Attending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number arlan

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yudhish Monkon 305 Hospital Dr., Glen Burnie, MD.

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death me of I Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Northwest Hospital Center Randallstown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F Min. Months Days Hours Director (Month 13, 1932 Couldaryland Yrs. 218-26-9635 78 Usual Residence of Decedent 28a-f shov filed within 72 hours after death with the Maryland al Hygiene. 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits **Baltimore** N/A Maryland 1 Yes 2 No 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21230 764 Ramsey Street items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 10 δ 1 Never Married 2 Married Black, White, etc. Maryland 21215-0036 ☐ Yes 2 👿 No If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: Black "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than matic event, the Me Elementary/Seconday (0-12) Dopkin Plumbing College (1-4 or 5+) Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file tment of Health and Mental rtant: If item 27 is marked or ijury or other traumatic eve Mental Marion Turner Roland Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 7655 So. Woodington Road Baltimore, Maryland 21229 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other t Linda Montgomery Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 08/03/10 Brooklyn Park, Md. 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery & Mausoleum Signature of Funeral Service Licensee 22. Name and Address of Facility
Estep Brothers Funeral Service, P KQ 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) ) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 as the t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year the 9 Unknown Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ◆ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of certificate has b lirector, page 2 sh 24a. Was an autopsy 1 Yes 2 🗌 No Yes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) 1 🗆 Yes မ 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: Natural 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Accident
Suicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ertifier License numbe Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Regi State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23618 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year GALBREATH DAVID 2279 3.35 AM 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE Palinent River Healit & Rehal Laurel George 5 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Oct | Months | Days | 1/9333 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☑ M 2 □ F California 560-42-4170 76 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits Prince Georges Laurel 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 20707 14200 Laurel Park Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 Armed Forces? 1 Armed Forces? 1 Never Married 2 Married white If Yes, Give Year or Dates: 1 ☐ Yes 21K No Specify. 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) veternarian animals 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Dewey Galbreath 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher Galbreath - son 7622 Zuni Street; Denver, Colorado 80221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state 21. Si ture of Luneral Service Ronald 22. Name and Address of FacilityState Anatomy Board Director 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Jause (Final disease or condition resulting in death)

a. Severe Partinsm's disease. Approximate Interval Between Onset and Death Years Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month Dav Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ilable e of

Physician /Medical Examiner law requires that the death certificate be executed and burial-trar Division of Vital Records, P.O. Box 68760, attending physician the as asn signed by the all be detached to has page 2 Hospital or Attending Physician: The certificate

Examiner Physician/Medical \$ Completed Be Medical Certification: To n 24 hours after death.

le Funeral Director: A pletely filled in by the fu completely

**Physician** 

/Medical

Director

Funeral

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Completed

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Examiner

**Funeral** 

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Experience at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Means."

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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Dementia		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munk
Recurrent A	spiration Pneumonia	24a. Was an autopsy performed?  1 Yes 2 Alo 24b. Were autopsy findings ava prior to completion of caus death?  1 Yes 2 No
25. Was case referred to medical examiner?	26. Place of Death	(Check only one)
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Hom	ne 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Vork?	8d. Describe how injury occurred
3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street and Number or Rural Route Number City or Town, State)
29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Exar	nysician: To the best of my knowledge, death occurred at the time, date and place, a miner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	and due to the cause(s) and manner as stated. and at the time, date and place, and due to the cause(s)

29c. License number

Bowne

53411

Shesadri

29d. Date signed (Month, Day, Year)

20715

2279 2010

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

checker

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Gallant Fix

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LM # 32. Registrar's Signature

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 0 1 0

		•	1 - State Registrar	Cer	tificate of l	Death	Reg.	No.	
			Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Agnes Frances Griffit	.h			July 2		9:55р м
1	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Death	1
			Heritage Center  5. Social Security Number 6. Sex 7. Age (h		Dunda			Baltin	
	Funeral		1 40 4 60 5	n yrs. last birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	nplace (State or Foreign untry)
	Director		213-20-5474 1 M 2X 1 89	, ,,,,			12-23-1	920 PA	•
	land			c. City, Town or Loc	ation				10d. Inside City Limits
	Mary -f sh	į	MD Baltimore	Dundal	k				1 ☐ Yes 2 ☐ No
	r 28a	irec	10e. Street and Number	,	10f. Zip Code		10g.	Citizen of What Cou	ıntry?
	3a o	Funeral Director	7232 German Hill Rd.		21222			USA	
	death	ner	11. Marital Status 12. Was Decedent Ever Armed Forces?	r in U.S. 13. W	Vas Decedent of H	ispanic Origin? (Spe an, Mexican, Puerto i	cify Yes or No-	14. Race - Amer Black, White	
٥	after or ite		1 Never Married 2 Married 1 Yes 2 No		□Yes 2□No	Specify:	110017	Cresitu	
0000	ours	d by	3 Widowed 4 □ Divorced Year or Dates:					W	hite
ក្ត	72 h "natu	Completed	15. Decedent's Education (Specify only highest grade completed)	I (Give k	ent's Usual Occup kind of work done of OO NOT use retired	during most of workir	ng	o. Kind of Business/li	
V	vithin sne. than	E G	Elementary/Secondary (0-12) College (1-4or 5+)	Cle		"	H	ochild F	Kohn
V	Hygie Hygie Int,		12th 17. Father's Name (First, Middle, Last)	CIE.	IV	18. Mother's Name	(First, Middle, Maid	den Surname)	
	ld be filed lental Hygi <b>ked other</b> ic event, I	Be c	Terrence McCort			Ellen	Carrahei	c	
5	should be filed within 72 hours after death with the Maryland that Maryland hard Hygiene. I will Maryland sinarked other than "natural", or items 23a or 28a-f show umatic event, I'm Marical Evancines mare the notified at	욘		hter9b. Mailing	a Address (Street	and Number or Rura	I Route Number, Ci	ity or Town, State, Z	ip Code)
2	nd 2 s lith ar 27 is 7 risu		Rebecca Sellers					ore, MD	
Ď.	f Hea			20b. Place of Dispos		D	ate 20c	c. Location - City or T	Town, State
2	ages ento nt; If I	'	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation _ 5 ☐ Other (Specify)	Holly H	$\mathtt{ill}$	7/29/	⁷²⁰¹⁰  Ba	ltimore	,Maryland
Daillimor	permit. Pages 1 and 2 should be Department of Health and Mente Important: If Item 27 is marked any Injury or other traumatic evonce.		21. Signature of Funeral Service Licensee	22.	Name and Addre	ss of Facility	onh N	7222120	Tr FH
ŏ	Depa Impo any Ir		1 / harl/	26	3 S. Co	onkling	St, Balt	Zannino imore,Md	21224
		7 1	23a. Part 1. Enter the disease of complicitions that caused the shock, or heart failur List only on cause on each line.	death. Do not ente					Approximate Interval Between
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	atten for us	ian,	23b. Was decedent pregnant in the past 12 months?  4 □ Pregnant at tim	Fetal death 3	Ectopic pregnanc Other (specify) _	у		23d. Date of deli Month	Day Year
5	the d	Physician	1 ☐ Yes 2 🗹 No 9 ☐ Unknown	le oi dealii 5 🗆	Other (specify) _				
r,	that t		Part II. Other significant conditions contributing to death but no	ot resulting in the un	derlying cause giv	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ָרֻ מ	urres sign d be	d by					1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Tonknown
Spicos	v req beer shoul	Completed					24a. Was an	24h. Were au	topsy findings available
ב ב	e has	d				<del></del>	autopsy performed	prior to c	completion of cause of
ē '	n: II ificate or, pa	ဝင္	25. Was case referred to medical			OC Place of Dooth	1 Yes 2	Yo 1 ☐ Yes	2 <b>2</b> No
5	s cert irect	20	examiner?  1 Yes 2 1 10 Inpatient	2 ER/Outpatient	t 3 DOA Oth	er: 4 D Nursing Ho		e 6 Other (Spec	oifu)
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NISION OF	th.	ioite	1 ☑ Natural 5 ☐ Pending (Month, Day, Ye 2 ☐ Accident investigation	ear) Injury		Yes 2□No			
2 :	Arte	ific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc. (3	- At home, farm, stre	et, factory, office	:	28f. Location (Stree City or Town, S	et and Number or Ru	ral Route Number,
5	al or s afte al Dir	Sert	4	эреспу)			Ony or Town, o	rare)	
	ospir hour unera		29a. Certifier (Check only (Check only 2 Medical Examiner: On the basis of ex	ny knowledge, death	occurred at the ti	me, date and place,	and due to the caus	se(s) and manner as	s stated.
3	To the rospital or Attending Priystcian: The law requires that he death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	one) and manner stated						
i	vith To t	Σ	29b. Signature and title of certifier	001	29c. Licens	e number		Date signed (Month)	
			Savinder 10 Tulla	IVI.D.	26	1108	1 ,		
	VV		30. Name and address of person who completed cause of death	1 (Item 23a) (Type, E	Print)	and alle	MD 2	1295-	
	7		31 Date filed (Month TOW's Year)	Signature	juice of	maan	119 11	cri	
	Sta Registr	te ar	30. Name and address of person who completed cause of death SOVINGE IC JULIG 2 MC 31. Date filed (Month, Day, Year) 32. Registrar's 32. Registrar's	1 A A	harles				

amend item 25 per me g905 7-29-10 yt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 2010 6:46 PM TULY Grzechowiak W. Robert /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAUTIMORE HUSPITAL AGNOS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 29, 1938 Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 □XM 2 □ F Maryland 219-38-5977 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show traumatic event, the Medical Evandant outst be notified at 1⊠Yes 2□No Md. Baltimore City 28a-f 10g. Citizen of What Country? 10e Street and Number 23a or U.S.A. 21216-2503 3500 Clifton Avenue Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0036 "natural", or White 1 ∐Yes 2√∑No Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grocery 0 Stock marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fill and Mental F John Grzechowiak Antoinette E. Wisniewski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4500 Dunton Terr. Unit P, Perry Hall, Md21128 Bruce Grzechowiak-nephew Health a permit. Pages 1 and 2 Department of Health Important; If item 27 i any injury or other tra once. Saltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) July Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 28, 2010Baltimore, Maryland Holy Rosary Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility aczorowski Funeral Home, P.A 21. Signature of Funeral Service Licensee Robert 1201 Dundalk Avenue Baltimore, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 40 MNUTES FOOD ASPIRATION, **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical CENTRICA IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No nis certificate has been signed by the director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed grezchowiak, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐Yes 2 ☐No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 € Certification: To this funeral 28a. Date of Injury (Month, Pay, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 1 □ Natural 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Af SUBJECT ASPIRATED FOUD 1800 1 ☐ Yes 2 XNo 2 Accident 7/25/10 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 3010 CLIPICA TVE. 4 Homicide LIVING BALTIMINE w Lacrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DU051865 CATON AVE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CURTIS Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#17, 18, 20a-c, 22perff, 6905, 7/29/2010, w5

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 20 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Frederick Hill 23Day July Medical 1500 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death laryland 4c. County of Death Baltimore HOSPIta teneral Funeral Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Director 219-26-8752 Jan 18, 1941 69 Hours Min. Mary Tand Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medica Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 501 W. Franklin Street 21201 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 Never Married 2 Married þ 1 ☐ Yes 2 ☒ No If Yes, Give Black, White, etc. Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes 2 X No Specify. Specify: black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) is marked other machinist furniture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important, If item 27 is marked any injury or other traumatic ev 2 Julius Hill Sr. Mildred Davio Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loretta Hill - wife 3012 Virginia Ave; Baltimore, Maryland 21215 20a. Method of Disposition
1 □ Burial 2 🔀 Cremation 3 □ Removal from State
4 □ Donation 5 🔂 other (Specify) 11 BEALE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metro Crematory 7-28-10 Catonsville,MD 21. Signature of Funeral Service Licensee Ronald S Wade Gary P. March runeral Home 270 Pedi Halton Pass Baltin 23a. Part 1: Inter the dise ye, or complications that caused shock, or leart failure. List only one cause on each line. Immediate Caus. The impre_{n 200} 21201 t Baltinore or of plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Physician/ myocardia Onset and Death disease or condition Medical resulting in death) Que to (or as a consequence of): Examiner Spiratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): 14 Due to (or as a consequence of) attending physician Be Completed by Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant Live Birth 2 Live Felan 302

Pregnant at time of death 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Year Day 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician; The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has be irector, page 2 s 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy Yes 2 N 25. Was case referred to medical director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 🗆 Yes 2 **X**No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director, After this completed filled in by the funeral of 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? Accident Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ver Den 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23622 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Mildred V. Howard /Medical Ju₁v 2010 2:00 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 600 Bear Branch Road Westminster Carrol1 5. Social Security Number 8. Date of Birth (Month, Day, June 16, 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland **Funeral** 7. Age (In yrs. last birthday) ^{Year)} 1925 Days Hours 1 □ M 2 🖾 F 213-20-6076 Director 85 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evancian must be matter militared anone. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Westminster Carroll 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 600 Bear Branch Road 21157 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 1 □Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐Yes 2√∑No Specify: white Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Unk Elementary/Secondary (0-12) College (1-4or 5+) housekeeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Walter Farinholt ဥ Mildred Catherine Harrison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Merrill Howard - husband 600 Bear Branch Road; Westminster, Maryland 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4x Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board Ronald S. Wad 655 W. Baltimore St.; Baltimore, MD 21201 Rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Buggert /Medical Due to (or as a consuluence of): Examiner Swife Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans leba Due to (or as Division of Vital Records, P.O. Box 68760 Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2. No 2 □No 1 □ Yes 1 ☐ Yes funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Hospital: Medical Certification: To After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a. Certifier 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Pay)

and address of person who compresed cause of death (Item 23a) (Type, Print)

M

32. R

gistrar's Signature

L. Falsbu

1310 Magkess

29c. License number

5

29d. Date signed (Month, Day, Year) 07-21-2010

Elleliburg, MD

)-0555/		Please Type or Print in Black Indelible Ink. Ensure All Copie		gible.	22622
/illiam Heiger		State of Maryland / Department of Health and Mental Hyll-For State Certificate of Death	_		23623
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Dea	eg. No. th	3. Time of Death
ledical Exami		WILLIAM JOSEPH HEIGER	Month July 25, 20	Day Year 010	1055 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Dea	th
		Johns Hopkins Bayview Medical Center Baltimore		N/A	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs  On the security Number 1. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs  Months Days Hours Min.	_	th(MM/DD/YYYY) 9. B Fore	ian
Director		220-42-7824 1AM 2 F 08 Yrs.	JULY 1	3,1942 c	ountry) MD
any	1	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
<u> </u>		MD N/A BALTIMORE			1 X Yes 2 No
daryland 28a-f show 1 at once.	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Co	untry?
IMORE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once	ä	5517 GERLAND AVE 21206		USA	
ms 23	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 1) Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		- 14. Race - Ame White, etc.	rican Indian, Black,
r death	Fun	1 Yes 2 X No	Triban, etc.)		
"hours after "natural", Examiner	盃	3 Widowed 4 Divorced It Yes, Give Year 1 Yes 2 X No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v	work done	Specify: W.  16b. Kind of Business	HITE
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036 ithin 7 ne.	Completed	12 OPTICIAN		DOCTORS V	ISION WORKS
5-0 led w Hygie other		17. Father's Name (First, Middle, Last) 18.Mother's Name		Maiden Surname)	
21215-0036 Muld be filed within 7 Mental Hygiene, marked other than c event, the Medica	Be	CHARLES HEIGER MARIE B		-b 0:t T 0t	T-0-4-)
nore, MD 21215-0036 ges I and 2 should be filed within 72 and 9 Health and Mental Hygiene.  1: If item 27 is marked other than other traumatic event, the Medical	리	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or F ROSEMARY HEIGER-WIFE 5517 GERLAND AVE BA		, MD 21206	e, Zip Code)
ore, MC ss I and 2 s of Health a If item 27 her traum	ł	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City of	r Town, State
nt of H		1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Departing 5 Other Specify: ATLANTIC CREMATORY 7/	28/10	GLEN BURN	TE. MD
Baltimore, permit. Pages I an Department of Her Important: If ite injury or other tr	1	4 Donation 5 Other Specify: ATLANTIC CREMATORY // 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MTL			
F. F. P. P. E.		6415 BELAIR RD BA	LTIMORE	, MD 21206	
Physician		23a. Part   Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one gause on each line.	r respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
Examiner	i	Immediate Cause (Final disease a Hypertensive Atherosclerotic Cardiovascular Disease Complice	cated by Che	est Injuries	Death
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	Je	Sequentially list conditions, Due to (or as a consequence or).  Cause. Enter Underlying Cause			3
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hat the ed by letach		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute t	
tal Records, P.O. cian: The law requires that th certificate has been signed by ector, page 2 should be detach	Completed by	Diabetes Mellitus		s 2 No 3 Pro	
ords, aw requir as been s	plet		24a. Was autop	prior to	utopsy findings available completion of cause of
Rec The la	팃		1 ✓ Yes	rmed? death?	
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?    Hospital: 1  Inpatient 2    ER/Outpatient 3  DOA    Other    Nursin			
of Vi ing Physi After this	은	1 Yes 2 No	19 Home 5	Residence 6 Oth	er:
on of \nding Physical refuneral	ion	1 Natural 5 Pending FOUND: Day, Year) FOUND: 1 Yes 2 ✓ No		from ladder	
risic r Atte ter dea irecto	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.			tural Route Number, City
Div	Certification:	4 Homicide determined (Specify) Single Family Home	or Town, S 5517 Gerland	State) Avenue, Baltimore,	MD
E Hosp 24 hc Func etely f		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	due to the caus	se(s) and manner as sta	ated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the built	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	it the time, date		
	2	29b. Signature and title of certifier  29c. License number  O.C.M.E.		29d. Date signed (M) July 27, 2010	опит, рау, теаг)
		My Draney MA		July 27, 2010	
9		<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD</li> </ol>	21201		
U	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

OCME

10-05493 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Shalanda Haywood State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day July 23, 2010 0135 hrs Medical Examiner Shalanda Haywood 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard 8. Date of Birth(MM/DD/YYYYY) 9. Birthplace (State or Foreign NY Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Min. Months Days Hours Director Aug. 17, 1972 024-56-2682 1 M 2 X F 37 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. or items 23a or 28a-f shomust be notified at once, Howard Co. Columbia 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 21046 9355 Guilford Rd 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-14. Race - American Indian. Black. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married Yes 2 x No nt of Health and Mental Hygiene.

1t: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner 1 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify.Black Þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry leted during most of working life. DO NDT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Private Compl 4+ Domestic 17. Father's Name (First, Middle, Last) UTH 18.Mother's Name (First, Middle, Maiden Surname) Tillman Brenda Mizell Ernest Mizell 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9355 Guilford Rd. Columbia, MD 21046 Brian T Haywood/Husband 20c. Location - City or Town, State **Waldorf** 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, timore, Heritage Crownsville Cemetery 1 Burial 2 Cremation 3 Removal from State 20601 lle, MD 8-4-2010 4 Donation 5 Other Specify. 22. Name and Address of FacilityRonald Taylor II Funeral Hm Signature of Funeral Service Licensee 108 W. North Ave. Baltimore, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Driset and /Medical Death Immediate Cause (Final disease Asthma Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) events resulting in death) Last and transit sician/Medical 20b,c per fh g906 8-3-10 vt 23a,27 per me g912 2-18-11 X UNPENDED X AMENDED attending physician for use as the burial Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 1 Live birth 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown for n signed by the and be detached for Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 ✔ Unknown Completed this certificate has been s I director, page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? 1 🗸 Yes ✓ Yes 2 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🗌 DOA Other Nursing Home 5 Residence 6 Other 1 V Yes 2 After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification 1 X Natural 5 Pending 1 Yes 2 No Fo the Funeral Director: filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 📝 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME July 23, 2010 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 DCME 2006

State Registrar

	1- For State Registrar	ite of Maryland			Health a Death	ind Me		Re	g. No. 20	0	23625
Physician/ Medical Examiner	Decedent's Name (First, Middle Edward Haynie	,Last)						Date of Death Month July 27, 20	Day Yes		3. Time of Death 1520 hrs
	4a. Facility Name (if not institution 2230 Christian Street	, give street and number	er)		b. City, Town, Baltimore		of Death		4c. County o		
Funeral Director		5. Sex 7. 7	Age (In yrs. last b	oirthday) Yrs		ear If Un ays Hou		8. Date of Birt	h(MM/DD/YYYY	9. Birth Foreign	
<b>,</b>	Usual Residence of Decedent	1 2 M 2 F		-	JL	l		1/10/1	933		1110
od how any cc.	10a. State 10b. County	n/a	10c. City, Tow Balti	in or Locat imore	on						10d. Inside City Limits  1 X Yes 2 No
the Maryland n or 28n-f show tified at once. Director	10e. Street and Number		1,	-	10f. Zip Code			10	g. Citizen of Wh	nat Count	try?
death with the Maryland or items 23a or 28a-f abo must be notified at once. Funeral Director	2230 Christian  11. Marital Status	12. Was Decede	ent Ever in U.S.	13. Wa	21 2 s Decedent of		rigin? ( Spec	ify Yes or No-	USA 14. Race	- Americ	an Indian, Black,
	1 Never Married 2 Mar 3 Widowed 4 Divor	1 Yes	s? 2 X No	If Y	es, specify Cul			can, etc.)	White Specify:	e, etc. Whi	te
hours after a matural?  Examine	15. Decedent's Education (Special				t's Usual Occu	pation (Giv			16b. Kind of Bu		_
5-0036 ed within 72 hour 15 yeare. other than "natu the Medical Exam	Elementary/Secondary (0-12)	College (1-4 o	or 5+)	Wax	rehouse	man			Wareh	ouse	2
Baltimore, MD 21215-0036  bernit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner  To Be Completed by I	17. Father's Name (First, Middle, L Wiaklin W. Hay	-	•			100			laiden Surname Linnbu		
Baltimore, MD 21215-C permit. Pages I and 2 should be filed to Department of Health and Mental Hygi Important: If item 27 is marked oth injury or other traumatic event, the 1 To Be Co	19a. Informant's Name/Relationshing Thomas D. Hayn	ip (Type, Print )				reet and Nu	umber or Rur	al Route Num	ber, City or Tow	n, State,	
e, MI I and 2 s Health a item 27	20a. Method of Disposition		20b. Place	e of Dispos	ition (Name of			Date Balt	imore,		
imor Pages ment of lant: Lf or other	1 Burial 2 X Cremation Donation 5 Other Spe	ecify:	otate	atory or oth	cremato	ry	7/28	3/2010	Baltim	ore,	Maryland_
Balt permit Depart Import injury	21 Signature of Funeral Service L	icensee		22. N	ame and Addr )7 Wilk	ess of Facil	ity Huk Venue	obard F . Balti	uneral .more, M	Home	, Inc.
Physician (Medical	23a. Part I. Enter the disease, or of failure. List only one cause of		ed the death. Do								Approximate Interval Between Onset and
xaminer	Immediate Cause (Final disease or condition resulting in death)	Atheroscleroti  Due to (or as a cor		ular Dis	ease					-	Death
Pe	Sequentially list conditions, if eny, leading to immediate	b. Due to (or as a cor	nsequence of):							-	
ramir ramin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cor	nsequence of):								
D, be executed sician and urial - transit edical Examine	UNPENDED	d							<del></del>		
	IF FEMALE:	23c. If yes, outo	ome of pregnanc	у					23d. Date of	delivery	
he death certificate by the attending physiched for use as the broken Physician/Me	23b. Was decedent pregnant in the past 12 months?	4 Pregnant	at time of death		tal death ner (Specify)	3Ector	oic pregnanc	у	Month	Da	ay Year
P.O. Bo that the deat oned by the at detached for by Phys	1 Yes 2 No 9 Unkn	9 Unknown	ath but not result	ing in the u	nderlying caus	e given in F	Part I.	23e. Did tot	pacco use contri	bute to th	ne cause of death?
S, P.C nires that n signed b d be deta								1 Yes	2 No 3	Proba	ably 4 🗹 Unknown
Records, The law requires ficate has been sig , page 2 should bb			<del>-</del>					24a. Was a autops	sy p		opsy findings evailable ompletion of cause of
ital Reccitions: The lav	25. Was case referred to medical	1			26.Pla	ice of Deat	h (Check onl		No 1	Yes	2 No
f Vita	examiner?  1 ✓ Yes 2 No  27. Manner of Death	Hospital: 1 Inpa		Outpatient		Other ₄	Nursing I		Residence 6 v		Scene
ion of tending Pheath.	1 Natural 5 Pendir 2 Accident Investi	(Month, Day	(Year)	, Time of i	· ·   _	Yes 2	_	ou. Describe in	ow injury occurr	ou.	
Division of Vital Records, P.O. spital or Attending Physician: The law requires that the rours after death.  neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach  Certification: To Be Completed by P.	3 Suicide 6 Could determ	not be 28e. Place of	Injury - At home,	farm, stree	t, factory, offic	e building,	etc. 28	or Town, St		er or Rura	al Route Number, City
Division of Vital Records, P.O. Box 6876( To the Bespital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bedical Certification: To Be Completed by Physician/Me	29a. Certifier (Check only 1 Certifying Phy	rsician: To the best of iner:On the basis of ex	kamination and/o								
To with	29b. Signature and title of certifier	and manner state	d			nse numbe	r		29d. Date signe		th, Day, Year)
	30. Name and address of person w	the completed cause of	death (Item 22a	1	0.0	C.M.E. 			July 28, 20	10	
71	Patricia Aronica-Pollak	MD. Assistant	Medical Exa	,	111 Penn	Street, B	saltimore,	MD 21201			
State Registrar	31. Date filed (Month, Day, Year)	Server 32. Regist	rar's Signature	es!							

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM#2perPHYS, G905, 7/29/2010, WS

State of Maryland / Department of Health and Mental Hygiene 1 0 23626 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 7-25-2010 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number Town, or Location of Death 4c. County of Death Examiner (In yrs. last birthday) 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Min. 1 € M 2 🗆 F Months Hours Yrs. **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 ☐ No timore MO 10f. Zip Code 10g, Citizen of What Country? ò 10e. Street and Number ms 23a or must be r Funeral Raven Blud SA items 2 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or iter edical Examiner Armed Forces Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed and Mental Hygiene.
is marked other than "natu aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) conday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) ddle, Maiden Surname ဂ္ Page 1 and 2 should be ment of Health and Ment 27 is marked er traumatic e Jones Informant's Name/Relationship (Type, F 51Ster City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number to.MDa permit. Page 1 and 2 Department of Heath Important: If item 27 any injury or other tr once. 20c. Location - City or Town, State Method of Disposition 20b. Place of Disposition (Name of Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) crematory or othe cemetery 28/2010 emoria 21. Signature of Funeral Service Lice or ices 212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Due to (or as a consequence of): Physician/ HEGGA 2y15 ) Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Physician/Medical P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy sate has been signed by the atte page 2 should be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Monie autopsy 1 ☐ Yes 2 ☐ No certificate Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** director. Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 Yes 2 🗷 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) completed filled in by the funeral . Manner of Death 28b. Time of 28c. Injury at work?
1 \square Yes 28d. Describe how injury occurred Certificate: 5 Pending injury 1 X Natural s after death. 2 No Investigation ☐ Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number DD063657 M.D. 07/26/10 rais 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. 3312 54. Ste. 136 Baltimore, MD 21218 A. 31. Date filed (Month, Day, 200 atkins , Δ 32. Registrar's Signature State JUL 292010 Registrar

VO.	2	8	-	0	2	3	6	2
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<b>Physician</b>
/Medical
Examiner

**Funeral** Director

d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 10, 7 is marked other traumatic event, II 1 and 2 should be 1 Health and Mental

the

filed within 72 hours after

Maryland 21215-0036

Baltimore.

permit. Pages 1 and Bepartment of Health Important; If item 27 any Injury or other troone. Physician /Medical Examiner

27

sician and burial-transit attending physician for use as the buria cate has been signed by the page 2 should be detached certificate After this certifical funeral director,

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours a er death. Funeral Lirector A completely filled in by the within 2.

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygier for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month 23 00 PM **JAMES** 2010 LEVONZY 26 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITal Rosedal BacTimor Square FRANKLIN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8-15-1932 Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 77 239-32-2713 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 XYes 2 No Director BALTIMORE TURNER STATION MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21222 111 ROBERT CURBEAN LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Ves 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify Specify: þ 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) BETHLEHEM STEEL LABORER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LUCY JAMES ၉ CHESTER ELLIOTT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD 21222 111 ROBERT L. CURBEAN LANE HELEN JAMES/WIFE 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 4 ☐ Donation 5 ☐ Other (Specify) ON-SITE CREMATION 7-29-2010 BALTIMORE, MD 22. Name and Address of Facility S A. MORTON & SONS FUNERAL HOMI BALTIMORE, MD 21217 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES 1701-31 LAURENS ST. amis Approximate Interval Between Onset and Death 23a. Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. MRDIONASCULAR DISEOKI Immediate Cause (Final THEROSCLER disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OF ILUZE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check onl one) Be examiner? 1 Ves 2 □ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Cheg and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0060570 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADELPHIA RD. # 206, 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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State of Manyland / Department of Health and Mental Hydiene

nomas Augustus	1- For State Co	ertificate of Death	Reg. No. 2010 23	628
Physician/ ledical Examine	Decedent's Name (First, Middle,Last)		2. Date of Death  Month Day Year July 26, 2010  3. Time of Death 1346 hrs	
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
	5121 Harford Road  5. Social Security Number 6. Sex 7. Age (In yrs	Baltimore  If Under 1 Year If Under 24Hrs.	N/A  8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State of State of Birth (MM/DD/YYYY) 19 Birthplace (State of Birth)	or Foreign
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs 1217–68–4747 1XM 2F 52	Months Dove Hours Min	12/08/1957 Country Mary	land
*0 of	Usual Residence of Decedent  10a. State 10b. County 10c. Ci	ity, Town or Location	10d. Inside C	ity Limits
	Maryland N/A	Baltimore	1 X Yes	2 No
Maryland 28a-f show d at once.	10e. Street and Number	10f, Zip Code	10g. Citizen of What Country?	
feath with the Maryland ritems 23s or 28a-f she next he notified at once ust he notified at once unneral Director	5121 Harford Road	U.S. 13. Was Decedent of Hispanic Origin? (Sp.	United States ecify Yes or No- 14. Race - American Indian, Bla	ack
items	11. Marital Status 1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto		2011,
s after de	3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:	Specify: White	
hours a		16a. Decedent's Usual Dccupation (Give kind of w during most of working life. DO NOT use retir		
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland filth and Montal Hygiens n 27 is marked other than "ostural?", or items 23a or 28a-f she aumatic evect, the Medical Examiner must be notified at once To Re Compilered by Furneral Director	Elementary/Secondary (0-12) College (1-4 or 5+)	Store Manager	Record Shop	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 permit Pages I and 2 should be filed within 7 limportact: If tiem 27 is marked other than injury or other traumatic evect, the Medica To Re Comple	17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Maiden Surname)	
2121 Ild be fill Mental H Marked eveot,		Carolyn	Sader ural Route Number, City or Town, State, Zip Code)	
MD 2 and 2 shoul lith and M m 27 is m aumatic	John W. Koester, II, Brother	#12 Berlang Road, Lond		
Te, No. 1 and 1 Health	20a. Method of Disposition 20	b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State	
Pages nent of	1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:		7/2010 Baltimore, Maryla	nd
Baltimore, permit Pages I ai Department of He Importact: If ite	21. Signature of Funeral Service Licensee Amanda Heas		ation Society of Maryland , Baltimore, Maryland 212	
Physician	23a. Part I. Enter the disease, or complications that caused the dea	ath. Do not enter the mode of dying, such as cardiac or	respiratory arrest, shock, or heart Approximat Between 0	te Interval
/Medical	failure. List only one cause on each line.  Immediate Cause (Final disease a. <b>Methadone</b>	Intoxication	Des	
Examiner	or condition resulting in death)  Due to (or as a consequence	e of):		
	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence	e of):		
red instit	cause. Enter Underlying Cause (Disease or injury that initiated  c.  Due to (or as a consequence	e of):		
an and all - transit	events resulting in death) Last Due to (or as a consequence d.			_
		7,28a-f per me g906 8-10 per me g906 8-25-10 vt		
certificate be niding physici use as the buri	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of printing the 23c. If yes, outcome of yes, outco	regnancy  2 Fetal death 3 Ectopic pregna	ncy Month Day	Year
the death certificat ty the attending phyched for use as the	past 12 months?  4 Pregnant at time of			
hed hed	Part ii. Other significant conditions contributing to death but no	ot resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of c	death?
P.O.			1 Yes 2 No 3 Probably 4	Jnknown
of Vital Records, og Physician: The law require ther this certificate has been si neral director, page 2 should b			24a. Was an autopsy 24b. Were autopsy findings prior to completion of co	
Recc The lav			performed? death?  1 ✓ Yes 2 No 1 ✓ Yes 2	No
	25. Was case referred to medical	26.Place of Death (Check  FR/Outpatient 3 DOA Other4 Nursin	only one)  g Home 5 Residence 6 ✔ Other: Scene	
on of Vital lending Physician: arth. or: After this certif the funeral director,	1 V Yes 2 No Inpatient 2  27. Manner of Death 28a, Date of Injury	ER/Outpatient 3 DOA Oute 4 Nursir  28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
ion c tending eath. for: Af	1 Natural 5 Pending (Month, Day, Year) 7-26-10	unknown	unknown	
*** =	2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of Injury - A	At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Nur or Town, State) 5121 Harford R	mber, City
		esidence	Baltimore, Md.	
Divis  To the Hospital or A within 24 hours after. To the Fuorral Direc completely filled in by	(Check only one) 2 Certifying Physician: To the best of my know one) 2 Medical Examiner: On the basis of examination	viedge, death occurred at the time, date and place, and on and/or investigation, in my opinion, death occurred a	at the time, date and place, and due to the cause(s)	
Ping Subject of the state of th	29b. Signature and title of centrier	29c. License number	29d. Date signed (Month, Day, Year	り
<i>)</i>	1/1 1 RIPPLA	O.C.M.E.	July 27, 2010	
MARINA	30. Name and address of person the completed cause of death (I Jack Titus MD. Deputy Chief Medical Exami		1201	
Stat	(c. 31. Date filed Month, Day, Year) 32. Registrar's Sign	nature		
Registra	50 30 30 40 40 40 40 40 40 40 40 40 40 40 40 40	Barkel		

		•	For State Registrar		State of M	aryland		artment of I tificate of I		and Men		iene _{eg. No.} 2010	23629				
	Physicia	an/	1. Decedent's Name (First, Middle, Last)  2. Date of Death									h	3. Time of Death				
	Medi	cal	Cheryl	Rae	Kauff give street and number)	ul costion of		July 26 2010 12:20PM									
_	Examir	ner	Gilchris					4b. City, Town, o	r Location of	or Death		4c. County of De					
	Funeral Director		5. Social Security N 215-02-6		6. Sex 1 ☐ M 2 💢 F	e (In yrs. las 42	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours		Date of Birth Month, Day, 01/20/	Year) 9. B 1968 Ma	irthplace (State or Foreign ountry) ryland				
	nd how at	Ļ	Usual Residence of 10a, State	Decedent 10b. County		10c. City,	Town or Loc	cation					10d. Inside City Limits				
	Maryla 18a-f s tiffied	Funeral Director	MD Howard Laurel										1 ☐ Yes 2 🛣 No				
	h the la or 2	al Di	10e. Street and Nur			10f. Zip Code				0g. Citizen of What C	country?						
	ath wit	uner	10809 Gr	aeloch	Road 12. Was Decedent	Ever in II C	10.1/	20723 Vas Decedent of H	ia-ania Orig	ing (Chaoit )	foe or No	9.55.65					
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fi		1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced  Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates.			If	Yes, specify Cuba	n, Mexican,			14. Race - Am Black, Wh Specify: W					
15-0	72 hou n "natu ledica	plet	(Spe	15. Decedent ecify only highes	's Education t grade completed)		(Give k	ent's Usual Occup	during most	of working		16b. Kind of Busines	s Industry				
212	within jiene.	S	Elementary/Seconday (0-12) College (1-4 or 5+)  Secondary (0-12) College (1-4 or 5+)  Horse Groomer							Racing							
pu	filed tal Hyg	To Be	17. Father's Name (		•	C. C				. '		faiden Surname)					
Maryland	ould be id Men marke matic	10.023 0003									n Drucilla Goya  ural Route Number, City or Town, State, Zip Code)						
	d 2 shealth ar				ll / Sister			,				jewater, M					
Baltimore,	ge 1 and It of Hei If item or othe		20a. Method of Disp 1 Durial 2		3 Removal from State	ce	metery, crem	sition (Name of natory or other plac	ce)	Date		20c. Location - City o	·				
altim	nit. Pagartmer ortant injury			4 Donation 5 Other (Specify) Anatomy Gift:s Registry 07/27/2010 Hanover  Signature of Fundral Sovice Usersee Jos RPH L. CINB 22. Name and Address of Facility Anatomy Gifts Registry													
B	permi Depar Impo any ir		De pala	The t	/ /	0078	_						, MD 21076				
	Physician/		23a. and Differ the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List of ly one cause on each line.  In the later cause (Final subset or condition equition)  The to (or as a consequence of):														
4	Medical Examiner		disprise or condition feetiling in death)  a.   ALCOHOLIC CIRL HOSIS										MONTHS				
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7or	ecuted and -transi	Examiner	Cause (Disease or that initiated event resulting in death)	iinjury s	c. Due to (or as	a conseque	ence off:										
0	cate be executed physician and s the burial-transit	edical	,		d		,										
68760	rtificate ing phy e as the		IF FEMALE:														
Box 6	To the Pospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy  1 Live Birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)									23d. Date of d Month					
P.O.	that the	by Pt	Part II. Other signif	icant condition	s contributing to death b	ut not resul	Iting in the ur	nderlying cause giv	en in Part I.		23e. Did tob	acco use contribute t	o the cause of death?				
rds,	equires een sig rould b	eted								- 1	1 🗌 Ye		Probably 4 Unknown				
Division of Vital Records,	: The law r cate has b page 2 st	Completed									24a. Was an autops perforn 1  Yes 2	y prior to ned? death?	utopsy findings available completion of cause of				
/ital	sician s certifi lirector	To Be	25. Was case referred examiner?  1  Yes 2	ed to medical	Hospital:	ant 2 🗆 🗆	R/Outpatien	Oth	ar.	h (Check only		o [\$ ou - o	city) HOSPICE				
of	ng Phy fter this ineral c		27. Manner of Death		28a. Date of inju	ry 2	28b. Time of injury	28c. Injury	/ at			nce 6 🔀 Other (Spe w injury occurred	city) 17037 (4				
sion	uttendi death. stor: A y the fu	Certificate:	2 Accident 3 Suicide	Investiga 6  Could no	ot be 280 Place of Init	in/ - At hom	no form etro	M 1 🗆	Yes 2 1	-	acation /Ct-	eet and Number or R	ural Dauta Alumbar				
Divi	tal or A rs after al Direct ed in b		4 D Homicide	determin	building, etc		ie, iaiii, sue	et, factory, office			City or Town,		drai noute Number,				
Sectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the page of the page										me, date and	place, and due to the	cause(s) and manner stated.					
	Vith with Con		29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year														
	1		30. Name and addre	ess of person wh	no completed cause of d	eath (Item 2	23a) (Type, Pr	rint)	4701	D		JULY 26,					
	<u>(</u>		DANIELL	E DOBE	RMAN, MD	6701	Non	ARUS ST	, 8MI	TE 4105	84	inmene,	NO 21204				
	Stat Registra		31. Date filed (Monta	29 2010	32. Registra	ar's Signatur	sake	,									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#23a, perPHYS, G906, 8/6/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death JUL L Physician/ SIEGFRIED 5.45 AM < LEEM AN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 4730 ATRIUM COURT, APT. 271 OWINGS MILLS 6. Sex 1 **X** M 2 □ F Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) GERMANY Months Days Hours Min. 0872871913 96 214-12-3856 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 X No BALTIMORE OWINGS MILLS MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21117 USA 4730 ATRIUM COURT, APT. 271 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, was Decedent Ever Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 al Hygiene.
d other than "natural", o 1 ☐ Yes 2 X No Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SALES REPRESENTATIVE MEN'S APPAREL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic ever 2 LOUIS KLEEMAN LENA BAMBERGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2240 CHARTER POINT DRIVE, ARLINGTON HTS, IL 60004 HOWARD KLEEMAN/SON Baltimore, 20a. Method of Disposition 20b. OHEW REPOSEMENTATIONS 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State CHESED CEMETERY 7/28/2010 RANDALLSTOWN, MD 4 Donation 5 Other (Specify) Signature of Fungral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. ·W 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Pancreatic Cancer Onset and Death Immediate Cause (Final -Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and I-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year n signed by the a ld be detached fi 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, has been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy , page performe death? After this certificate 200 Yes 25. Was case referred to medical **Division of Vital** director, Be 26. Place of Death (Check only one) examiner? Other: 2 E No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide injury work?
1 Yes 2 No To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 28551 airi MIN 1.014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAUNMI SYNS CAKHAMI AVE, SUITE 203 ASNEEM 2835 SMITH mi 31. Date filed (Month, Day, Year, 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JULY Physician/ 2010 25 WARREN KOMINS 11:05 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 35 FARMHOUSE COURT BALTIMORE BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 04/08/1933 Days Hours 1 X M 2 🗆 F 218-28-9819 **Director** MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XIX No BALTIMORE BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 35 FARMHOUSE COURT 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed Year or Dates WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+)
5+ EXECUTIVE REAL ESTATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ KOMINS RHEA **ADLER** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LYNNE KOMINS/WIFE 35 FARMHOUSE COURT, BALTIMORE, injury or other Baltimore, 20a. Method of Disposition 20b. Risce of Disposition (Name of Compact, Crementary) of differ place; 20c. Location - City or Town, State Date permit. Page 1 and Department of I lumbortant; If ite any injury or of 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) AITZ CHAIM CEMETERY 7/26/2010 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS. 8900 REISTERSTOWN ROAD, PIKESVILLE, 21. Signeture of Funeral Service Licen ee INC. 21208 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam Physician: The law requires that the death certificate be executed Cause (Disease or linjury sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 🗀 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy page performed 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 1 No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director, of completed filled in by the Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

reene

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

20m1

31. Date filed (Month, Day, Year)

2010 23632 State of Maryland / Department of Health and Mental Hygiene Prince L. McLeod Certificate of Death 1- For State Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day July 23, 2010 1320 hrs **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number Baltimore 3809 Dolfield Avenue If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs, last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign MREY/AND Months Days Hours Director 65 1 M 2 F Yrs 215-46-6932 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location iny 10a State 1 Yes 2 No RALTIMORE 28a-f show MD 'natural", or items 23a or 28a-f sho Examiner must be notified at once. permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Opparmier of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatie event, the Medical Examiner must be notified at once Director 10g. Citizen of What Country 10e. Street and Number 3809 U.SIA. DOLFIELD 12. Was Decedent Ever in U.S. Armed Forces? 1965 Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 1 Yes 2 No Specify: BLACK f Yes, Give Year or Dates: 09/05/1967 1 Yes 2 No specify: 3 Widowed 4 Divorced <u>چ</u> 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 /2 UNKNOWN 17. Father's Name (First, Middle, Last) PRINTICE MCLEOD ANNIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOLFIELD AVE, BALTIMORE, MARYJAN) PRINCESS MCI OAUGHTER Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place)
GRERISOH FO 1 Burial 2 Cremation 3 Removal from State -04-10 OWINGS MILLS, MD Donation 5 Other Specify. Signature of Funeral Service Dicenses ind. AVE, BALTIMOR HGTS. 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Between Onset and failure. List only one cause on each line /M_dical Death e, Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical UNPENDED AMENDED After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial. Division of Vital Records, P.O. Box 68760. 23d. Date of delivery IE EEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 1 Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 ✔ Unknown chronic renal failure, diabetes mellitus Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed? Yes 2 V No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene DOA 1 🗸 Yes မှ 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28c. Injury at Work? Certification: 1 🗸 Natural 1 Yes 2 No Pending within 24 hours after death To the Funeral Director: ţ 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. July 24, 2010 30 Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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		•	For State Registrar	State of Ma	iryiano	•	tificate of L			ıtaı myç	GIELL Reg. N	2010	23633	
	Physicia	n/	1. Decedent's Name (First, Middle, Las Ruth	Malecki 2. Date of De Month				eath 27,2010 ear		3. Time of Death				
	Medic Examin	al	4a. Facility Name (if not institution, give	4b. City, Town, or Location of Death					4c. County of Death					
-	) Examin	01	2183 Lake Drive		Pasad	ena					rundel			
	Funeral Director		5. Social Security Number 6. Sec 213-28-8640	t birthday) Yrs.	If Under 1 Year Months Days		Min. A	Date of Birtl Month, Day UGUS C	h v, Year) 22	Q Rie	thplace (State or Foreign untry) Maryland			
	nd <b>how</b> at	٦c	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location         10d. Inside Cit										10d. Inside City Limits	
	Maryla 18a-fs tified	rect	Maryland Anne Arundel Pasadena										1 ☐ Yes 2 🗗 No	
	th the l 3a or 2 t be no	Funeral Director	10e, Street and Number				10f. Zip Code				_	Citizen of What Co	ountry?	
	ems 2	une	2183 Lake Drive	12. Was Decedent Ev	er in U.S.	13. W	/as Decedent of H Yes, specify Cuba	1122 ispanic 0	rigin? (Specify `	Yes or No-	-	USA 14. Race - Ame	rican Indian,	
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by F	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates.	Yes 2 No Yes, Give 1			Specif		n, etc.)		Black, White Specify:	e, etc. white	
15-0	72 hou "natu ledica	nplet	15. Decedent's Ed (Specify only highest gra			(Give k	ent's Usual Occup ind of work done	during mo	st of working		16b.	Kind of Business	Industry	
212	within giene.		Elementary/Seconday (0-12)	College (1-4 or 5+	-)	life. DO NOT use retired)					h	ousehold		
b	tal Hyg d oth event,	To Be	17. Father's Name (First, Middle, Last)	<del>-</del> .					her's Name (Fin		Maider			
Maryland	d Men marke matic	Ľ	Harry  19a. Informant's Name/Relationship (T)	ano Printi	Ow	ings		<u> </u>	lizabet		0.7	Schmi		
Ma	d 2 sho aith an 27 is rrtrau		Norbert Malecki				Lake Dr		Pasade			or Town, State, Zi _l 122	Code	
Baltimore,	Page 1 and ment of Hea ant: If item ury or othe		20a. Method of Disposition 1 ☑ ★Burial 2 ☐ Cremation 3 ☐	_	20b. Pla	netery, crem	ition (Name of atory or other plac		Date			Location - City or		
ltim	-: <del></del>		4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Light)		More		Memorial 7/31,2  2. Name and Address of Facility Start					Parkville Maryland		
B	permit Depar Impor any in		3111 Mountain Road Pasadena MD 2112											
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interest of the cause of the caus											
	Physician/ Medical											2.8	Onset and Death	
4	Examiner		CORONARY ARTERY DISEASE 12									1 year		
	ъ #	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	Due to (or as a consequence of):									
	kecute n and al-trans	Exan	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	conseque	nce of):								
094	cate be executed physician and the burial-transit	ledical Examiner	C	d										
687	rtifical ing ph e as th		IF FEMALE:	23c. If yes, outcome o	f						T			
Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Of the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	23b. Was decedent pregnant in the past 18 months?  1  Yes 2 No 9 Unknown				23d. Date of delivery  Month Day Year							
P.O.	es that the des signed by the signed by the signed is	by Ph										3e. Did tobacco use contribute to the cause o		
'ds,	requires been sig should b	ted							— L	1 🗆 ۱	Yes 2		robably 4 Unknown	
of Vital Records,	The law re cate has bu page 2 sh	Completed								24a. Was a autop perfor	ssy rmed?	prior to death?	topsy findings available completion of cause of	
ital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:			_ Oth	or:	ath (Check only					
of V	ding Phys th. After this funeral di	e: To	27. Manner of Death	1 ☐ Inpatie	/ 2	8b. Time of	28c. Injur	yat				6 Other (Spec	ify)	
on	ending eath. or: Aftu he fun	ficat	1 ■ Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not b		rear)	injury	M 1	Yes 2	□ No					
Division	al or Att s after do I Direct d in by t	Certificate;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At hom (Specify)	e, farm, stre	et, factory, office			Location (S City or Tow			ral Route Number,	
_	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: After the funeral Director of completed filled in by the funeral Director.	Medical	(Check 2 Medical Exami	sician: To the best of mer; On the basis of exice Practioner: To the b	amination a	and/or investi	gation, in my opini	on, death	occurred at the t	time, date a	nd plac	e, and due to the	cause(s) and manner stated.	
29b. Signature and title of certifier 29b. D 16354										29d. D	ate signed (Mont)	h, Day, Year)		
	61		30. Name and address of person who de	ompleted cause of de	ath (Item 2	3a) (Type, P	TON A	1/2	BAC	T	M	0 21	229	
	Stat Registra		31. Date filed (Month, Day, Year) — — IIII 2976	32. Pegistrar	's Signatu	1. 6	ald							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 11tem 26 per doc g905 /-29-10 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 23634 Reg. NZ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MERBAUGH Physician/ Month 2010 WILLIAM 4:20 PM JULY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 1 M 2 🗆 F Months Days Oct. Director 214-48-2207 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 X No Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 715 Wimmer Road 21061 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status er than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Lot Operator Retail Grocery injury or other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental F 7 is marked of ပ William G. Merbaugh Kate Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health an
Important: If item 27 is r JoAnn Bush Merbaugh (spouse) 715 Wimmer Road, Glen Burnie. MD 21061 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July Date 30 1 Burial 2 Cremation 3 Removal from State Meadowridge Cemetery 4 Donation 5 Other (Specify) 2010 Elkridge, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 23a. Pan/I. Enter the disease, or complications that caused the deshook, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ALTERIOSCUERATIC CARSIOVASCULAR Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown signed by the atte Month Day Pregnant at time of death 4 Pregnant
9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MORBID Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \) 24a. Was an autopsy performed? Yes 2 N certificate completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 2 🗌 No 1 Inpatient 2 K ER/Outpatient 3 IDOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [ only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) My JULY 26 021776 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. HANNIN ST SAZTIMORE ZIZZS

Registrar

State

31. Date filed (Month, Day, Year)

Box 68760

32 Registrar's Signature

23635 State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ JULY 2010 11:45 aM **EDWARD MEADS** DAVE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Southern Maryland Hospital Clinton 8. Date of Birth (Month, Day, ) Aug • 21 • 9. Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 🛣 M 2 🗆 F Year 1945 Director 64 429-82-5924 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item Z7 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes No Fort Washington Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 20744 13309 Colfax Dr. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Dept. of Agriculture Management Analyst vrs. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gertrude Thrower Edward Meads 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fort Washington, MD 20744 <u>Barbara A.</u> Meads - Wife 13309 Colfax Dr. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 7-30-2010 Landover, MD Harmony Memorial Pk. 4 ☐ Donation 5 ☐ Other (Specify) Signature VIII Service Licensee 23Marshall ass of Fullyeral Home of Maryland Suitland, MD. 20746 4308 Suitland Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on earth line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Marrio Sch Medical Due to (or as a consequence of): Sifase OBSTAUCTIVE fulu **Examiner** CHirmic Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this confidence has a constant of the Funeral Director. attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown sate has been signed by the a page 2 should be detached? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 **X**0No 3 🗌 Probably 4 🗌 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ORES autopsy performe death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 🗆 No 1 npatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural iniury 5 - Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number me + address of person who completed cause of death (Item 23a) (Type, Print) Fort WARHINGTON Ront Lam 11701 31. Date filed (Month, Day State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 | 0 23636 State of Maryland / Department of Health and Mental Hygiene

			cate of Death	Reg. N	lo.							
Physici Medical Exam		Decedent's Name (First, Middle,Last)		Date of Death     Month Da	y Year	3. Time of Death 0750 hrs						
neuicai Exam	mer	Jillian McLauc  4a. Facility Name (if not institution, give street and number)	thlin 4b. City, Town, or Location of Death	July 26, 2010	4c. County of Death	0/30 11/5						
		Maryland General Hospital	Baltimore									
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthgroup Greign  On the Days Hours Min. Poreign										
Director		215-25-9013   1 M 2 XF 20	Yrs.	Aug. 4	1989 ^{Cou}	ntry) MD						
any		10a. State 10b. County 10c. City, Town or Location 10d. Ins										
Maryland 28a-f show any d at once.	JO.	MD Baltimore										
or 28a-	Director	10e. Street and Number 7146 Gough Street	10f. Zip Code 21224	1	Citizen of What Count	ry?						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp		U.S.A.	an Indian, Black						
death y or item must b	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto		White, etc.	,,						
s after rral", o	by	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a	1 Yes 2 X No specify:	Trans	Specify: Whit							
72 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	<ul> <li>Decedent's Usual Occupation (Give kind of working life, DO NOT use retired</li> </ul>		o. Kind of Business/In	austry						
0036 vithin ' ene. er than Medica	mpl	12	Housecleaner		Merry Ma	ids						
21215-0036 vald be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle, Last)  Robert Francis McLaugh		(First, Middle, Maid y Lynn I								
212 ould be I Ment mark ic ever			9b. Mailing Address (Street and Number or F			Zip Code)						
MD nd 2 sh alth and m 27 is		4	918 Fawn Street Ba		<del>-</del>							
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumat		1 Burial 2 Cremation 3 Removal from State cremation	of Disposition (Name of cemetery, atory or other place)		c. Location - City or T							
Itim tit. Pag urtment ortant: ry or o		4 Donation 5 Other Specify: Oaklawn Cemetery 7-3-10 Baltimore,  21. Sig of Funeral cice Licensee 22. Name and Address of Facility										
Dept.	, il	dhi s	Jo 263 S. Conkling	seph N. St. Bal	Zannino to. Md.	Jr. F.H. 21224						
Physician /Medical		23a. Part I. Enter the discusse, or complications that caused the death. Do failure. List only the cause on each line.	not enter the mode of dying, such as cardiac or	respiratory arrest, s	shock, or heart	Approximate Interval Between Onset and						
Examiner		Immediate Came (Final disease or condition resulting in death)  a. Cocaine and Her	roin Intoxication			Death						
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d sit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Company of the Company of the Compa											
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit												
60, ate be hysicië e buriz	Medical	IF FEMALE: 23c. If yes, outcome of pregnance			23d. Date of delivery							
Box 687 ne death certific the attending p	ian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth Pregnant at time of death	2 Fetal death 3 Ectopic pregna	ncy	Month Da	y Year						
Box 687  e death certific  the attending p	Physician/	1 Yes 2 No 9 V Unknown g Unknown	5 Other (Specify)									
P.O.	by P	Part II. Other significant conditions contributing to death but not resulti	ng in the underlying cause given in Part I.		co use contribute to the							
fs, P.C quires that en signed l				1 Yes 2	No 3 Proba	psy findings available						
cords law requir has been e 2 should	Completed			autopsy performed	prior to co death?	mpletion of cause of						
Vital Recc ysician: The lar his certificate ha		25. Was case referred to medical	26.Place of Death (Check of	1 <b>Y</b> Yes 2	No 1 Yes	2 No						
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should be	o Be	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/0	[Othor: ==		dence 6 Other.							
ling Ph After t funeral	Ë	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b		28d. Describe how i	njury occurred							
Sior Attenc r death ector: by the	catic	2 Accident Investigation /-26-10 /		unknown	h and Number or Duce	Deute Musels - Oit						
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director:	Certification:	Suicide Could not be	amily house	or Town, State)  Baltimor	218 W. Mor e. Md.	Route Number City						
t Hosp 24 hou Frunce etely fi	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, do	eath occurred at the time, date and place, and	due to the cause(s)	and manner as stated							
To the within To the compl		place, and due to the										
	2	29b. Signature and title of certifier	29c. License number O.C.M.E.	<b> </b>	d. Date signed <i>(Mont</i> i l <b>ly 27, 2010</b>	n, ⊔ay, Year)						
20km	1	30. Name and address of person who completed cause of death (Item 23a)	_									
J P		Melissa Brassell, MD Assistant Medical Examiner	111 Penn Street, Baltimore, MD	21201								
Si	ate	31. Date filed (Month, Day, Year) 32. Rejectrar's Signature	hadel									

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death (008 Physician/ a M THOMAS L. McFAIL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Greneral N/A PAMORE 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M 2 🛣 F Min 2-21-1932 VIRGINIA 78 Director 231-36-3725 Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1 X Yes 2 No BALTIMORE N/A MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Completed by Funeral 21223 USA 2136 BOYD ST. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: BLACK 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CONSTRUCTION DRIVER -6--0-Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ GRACIE HARRIS RICHARD McFAIL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BOYD ST. BALTIMORE, MARYLAND 21223 BARBARA McFAIL(WIFE) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Dispo 1 X Burial emation 3 🗌 Removal from State 7-31-2010 BALTIMORE, MARYLAND MT. ZION CEMETERY 5 🛭 Other (Specify) HIBNER 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature ral Service Licens MARYLAND 21217 N. MONROE ST BALTIMORE Approximate Interval Between Onset and Death enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart fallure. List only one cause on each line. Immediate Cause (Final lassive h sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner pase Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Dav Year Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached to 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 Yes 2 No Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) etha somashekar. 827 Linden Ave

DHMH 17 Rev 7/2009

State Registrar

myand,

32. Registar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ Weston 10:30 aM Thomas Owens 010 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) yrs. last birthday **Funeral TX**□ M 2 □ F Months Hours Days 228-20-4402 VA 84 Director -28 - 1926Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 273 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 ☐ No MD Baltimore na 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3827 Ayrest Ct 21236 U S Α Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No Black, White, etc þ 1 X Never Married 2 Married 1 ☐ Yes 2 XNo Specify. Specify: Black If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Laborer Bethlehem Steel 10th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) မ James Owens Mary Bland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Randallstown, MD 21133 Darryl T. Owens-Son 8710 Winands Road 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date XXBurial 2 Cremation 3 Removal from State Garrison Forest 7-30-2010 Owings Mills, 4 ☐ Donation 5 ☐ Other (Specify) March East F/H 22. Name and Address of Facility Signature of Funeral Service Licensee 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that Approximate Interval Between shock, or heart failure. List only one cause 9 Immediate Cause (Final Physician/ 11-00 disease or condition resulting in death) Medical or as a consequence of): Examiner Ecen 5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying as a co sequence of Due t Cause (Disease or iinjury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be to 24 hours after death.

Funeral Director: After this contification. Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 5 Other (specify) 1 Yes 2 9 Unknown To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 2 No ျှ ☑ ER/Outpatient 3 ☐ DOA 1 Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 29d. Date signed (Month, Day, Year) 2010 ne and address of person who completed cause of death (Item 23a) (Type, Print) Loch Raven Boulevave 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 9 Registrar

			For	State of Maryland			lental Hygie	ne ວັດເດ	23639
			1 - State Registrar  1. Decedent's Name (First, Midda	tle Last)	Certificate of	Death	Reg.	NG, U I U	3. Time of Death
	Physici		MAHie,	PeAls			Month Jely	Day Year 20/6	10:25 PM
	/Medio		4a. Facility Name (If not institution	1 1	4b. City, Town, o	r Location of Death	(	4c. County of Death	<del>-1</del>
	Funeral	-	5. Social Security Number	edical Center  6. Sex 7. Age (In yrs. last	t birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign
	Director		214-20-4948	1 □ M 2 🗹 F 8 6	Yrs. Months Days	Hours Min.		24 30w	h Caroling
	land ow		Usual Residence of Decedent  10a. State 10b. County	y 10c. City, 7	Town or Location				10d. Inside City Limits
	e Mary Ba-f sh	ctor	MD	Ba	1timore				1 MYes 2 No
	a or 28	Funeral Director	10e. Street and Number	11. 1. 01	10f. Zip Code	11010	10g	Citizen of What Cou	ntry?
	death	nera	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of H	dispanic Origin? (Spe	ecify Yes or No-	14. Race - Ameri	
36	s after	by Fu	1 ☐ Never Married 2 ☐ Mail 3 ☑ Widowed 4 ☐ Divorce	If Yes Give	1 ☐ Yes 2 ☑ No	Specify:	nicari, etc.)	Black, White, Specify: 12	eic.
2-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Examinet must be redified at	ted b	15. Decede	ent's Education	   16a. Decedent's Usual Occup	pation		b. Kind of Business/Ir	ndustry
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7	filed with Hygiene. other than		17. Father's Name (First, Middle	, Last)	Dullet	18. Mother's Name	(First, Middle, Mai	den Surname)	A Arsenal
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Mar	nit. Pages 1 and 2 should be filed within 72 ho rartment of Health and Mental Hyglene. ortant: If item 27 is marked other than "natun hijury or other traumatic event, It of Safical e.		19a. Informant's Name/Relation	ship (Type. Print) (Quugnter)	19b. Mailing Address (Street	and Number or Rura	al Route Number, C	ity or Town, State, Zi	p Code)
	es 1 and 2 of Health a fitem 27 is r other tra		20a. Method of Disposition	20b. Plac	ce of Disposition (Name of netery, crematory or other place	nason 751	oate 200	c. Location - City or T	own, State
Baltimore,	ermit. Pages epartment of nportant; If it ny Injury or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3	3 Li Removal from State	insville Vit. (	em. 8/3/	10 C	rowns vii	le, MD
gall	permit. Departimonts any injource.		21. Signature of Funeral Service	Licensee	22. Name and Addre	ess of Facility	Funeral	1	
			23a. Part 1. Enter the disease, of	or complications that caused me death.	たし 2222 W Do not enter the mode of dyir	ng, such as cardiac	or respiratory arrest	Ito, MO	Approximate Interval Between
1	Physician		shock, or heart fallure. Lis Immediate Cause (Final disease or condition	st only one cause on each line.	noniA				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequen					
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09/89	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours attendeath.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		IS SERVICE	0.					
ğ	ath ce attendii for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal de	eath 3 Ectopic pregnanc	су		23d. Date of deliving	very Day Year
	the de by the a	hysic	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at time of deal 9 ☐ Unknown	th 5 ☐ Other (specify) _				
<u>,</u>	Physician: The law requires that the this certificate has been signed by the ral director, page 2 should be detached.	β	Part II. Other significant condit	tions contributing to death but not resulting	ng in the underlying cause giv	en in Part I.		cco use contribute to	
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ě	The law te has age 2 a	Jdwo					24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
ZI A	ctor, p	BeC	25. Was case referred to medica examiner?			26. Place of Death		No 1 ☐ Yes	2,0110
5	Physi r this c ral dire		1 Yes 2 No 27. Manner of Death		R/Outpatient 3 □ DOA Oth 3b. Time of 28c. Injur	4 L Nursing Ho		e 6 Other (Spec	rify)
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2	spital		29a. Certifier Certifyi	ing Physician: To the best of my knowle	edge, death occurred at the ti	ime, date and place,	and due to the cau	se(s) and manner as	stated.
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medica one)	Il Examiner: On the basis of examination and manner stated.	n and/or investigation, in my o	opinion, death occur			
	To To t	Σ	29b. Signature and title of certific	er of the second	29c. Licens	se number	29d	Date signed (Month	, Day, Year) 7 20/0
	Ω		30. Name and address of person	n who completed cause of death (Item 23	3a) (Type, Print)	3015	F. Pal	PACE	1 -010
	3		Brian	ornell, Marcy 1	Medical Cont		timore	MOZ	1202
	Sta Registr		31. Date filed (Month, Day, Year	32. Registrar's Signature	e				

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Clyde Ashton Paul 9:29 A. M Ju1v Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F Months Days Hours (Month, Day, Year) 03/10/1923 Country) Maryland Director 218 16 6069 87 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21225 226 - 8th Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. <u>Ş</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 X Widowed 4 ☐ Divorced Completed WW II White Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Coast Guard Marine Machinist 7th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Grover Cleveland Paul permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Ruby Ruark traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clyde Paul / Son 226 - 8th Avenue Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 07/28/2010 Meadowridge Mem. Park 21. Signature of Fureral Service Lice 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year 1 Yes 2 L 9 Unknown 2 No the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 🖄 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? certificate Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my existed, death and the cause of the c Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 31 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and plane, and due to the cause(s) and his make as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Hurem 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 202

State

Registrar

31. Date filed (Month, Day, Year)

29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DORIS Month 07 Year 2 0/0 FOLTIL OVE 2:50 4a. Facility Name (if not institution, give street and number)
2) 5 green St, Balkinne mp Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X**□ F Months Days Hours Min. 04/09/1944 Country) Director 66 MD 213-48-7670 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2√√√No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7101 TRAVERTINE DRIVE, UNIT 302 21209 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TEACHER **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည OSTROWSKY BENJAMIN MARY WINAKUR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STUART POLTILOVE/HUSBAND 7101 TRAVERTINE DRIVE, UNIT 302. BALTIMORE. MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH JACOB CONG. 7/26/2010 FINKSBURG, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Lice 8900 REISTERSTOWN ROAD, PIKESVILLE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Subara dinoid Physician/ Hemorrhage disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence or) signed by the attending physician and a be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed? Yes 2 25. Was case referred to medica examiner? the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 1 No 1 🔲 Yes ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 Watural iniury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 🗆 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Almai D 00 70 22 6 25 MO 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NI Saw University University of Maryland Medical Center 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** M 2 □ F 76 Yrs. 6-28-Director Usual Residence of Decedent ms 23a or 28a-f shom must be notified at 10b. County 10a, State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Funeral Director Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? U.S.A items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married ò Completed by Yes Yes, Give Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🗙 No Specify. "natural", 3 Widowed 4 Divorced Year or Dates. Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me BLIC College (1-4 or 5+) SCHOOL Elementary/Seconday (0-12) UNKNOUN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ HENRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLYN REDDIT 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 31-2010 BRITIMORE, Signature of Funeral Service Licensee THE DERRICK C. JONES F.H.P.A 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Let Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated as Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D28462 30. Name and addres person who completed cause of death (Item 23a) (Type, Print) ighway, Suite 210 Pasadena, Marvian à

Registrar
DHMH 17 Rev 7/2009

State

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		For State Registrar		Ola		ai y iai i		rtificat			aa	ontain 1	Reg. N	201	0	2364	4
Physicia	n/	1. Decedent's Name			Her	106	>		-			2. Date of De	eath 07	<b>/25/20</b> 1	lO Year_	3. Time of Dea	
Medic	al	Bernice A. Rutledge  4a. Facility Name (if not institution, give street and number)						4b. City	Town, or	Location	of Death	0 11 12					A ^M
LAditiii	2697 Walston Rd.									Airy		Carr					
Funeral Director	1 1 1 1 1 2 2 1 7 1								If Under 1 Year   If Under 24 Hrs.   8. Date of Birth   Months   Days   Hours   Min.   Min.   Month, Day Ye   8/14/19					9. Birthplace (State or Foreign Country)  DC			reign
		Usual Residence of	Decedent									0/14/	193	/	_		
Maryland 28a-f sho notified at	Director	10a. State	10b. County	:011		10c. City	Mt.	Airy								10d. Inside City Li	
vith the 23a or st be r								10f. Zi	p Code 2177	7 1			10g. C	10g. Citizen of What Country?  USA			
eath w tems	Funeral	11. Marital Status	aiston	12. Was	Decedent E	ver in U.S	. 13.	Was Dece	dent of Hi	spanic Ori	igin? (Spec	cify Yes or No	-				
0036 urs after d ural", or i	þ	1 Never Married 2 Married 1 Yes 2 No						1  Yes				Rican, etc.)		Black, White, etc.  Specify: White			
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Specify only highest grade completed) (Give Elementary/Seconday (0-12) College (1-4 or 5+)						dent's Usu kind of wo OO NOT us Cecept	ork done a e retired)	during mos	og				ndustry		
nd 2 filed w al Hygi d othe	Be	17. Father's Name (F	First, Middle, La	ast)				СОСР			er's Name	(First, Middle					
rylaı uld be i Ment marke natic e	욘	Harold										Simpson					
Mal 2 shor 27 is n		19a. Informant's Nai					L					Route Number				Code)	- 4
ore, and of Head of He		20a. Method of Disp	osition			20b. P	lace of Disp emetery, cre	osition (Na	me of			ate	T	Location - (		own, State	_
Baltimore, permit. Page 1 and Department of Hea mportant If Item my injury or other		1 🗆 Burial 2 🖟 4 🗆 Donation	5 Other (S)	pecify)	I from State	1	Carrol	1 Cr	emato	ory				Winf			_
Bal permit Depar Impor any in		21. Signature of Fun	eral Service Li	censee			1	urri	ed Adopt	reencilit	Funer	al Hom	ne &	Crema	ator m	y, P.A.	
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between															
Ph_sician/	0. 4	Immediate Cause (F disease or condition	Final	ny one cause	on each line	K	Roca	1	AN	Cer	1				1	Onset and Death	
Medical Examiner		resulting in death)  Due to (or as a consequence of):															
nsit led	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury													pe		
be executed sician and burial-transit																	
376C fficate   ig phys	Medi	IF FEMALË:		d													-
Division of Vital Records, P.O. Box 68760  To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burian	Completed by Physician/Medical	23b. Was decedent p in the past 12 n 1 Yes 2 9 Unknown	nonths?	23d. Date of Degrae of Deg									very Day Year				
S, P.O	d by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use cor									_		the cause of death				
ital Records, P.O. Boatian: The law requires that the descentificate has been signed by the rector, page 2 should be detached	omplete											_ perf	psy ormed?	pr	ior to co	opsy findings available ompletion of cause	able e of
tal Fisan: Tisan: Tisan: Tisan: Tisan: Ctor, po	Be	25. Was case referre examiner?	d to medical						26. Pla	ace of Dea	ith (Check	1 ∐ Yes only one)	2701	NOT	□ res	ar IVO	
f Vil	유	1 ☐ Yes 2 ☐ 27. Manner of Death		Hospital:	1 Inpatie		ER/Outpatie	patient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ne of 28c. Injury at 28d. Describe how injury occurred							y)		
on o ending eath. or: After	Certificate:	1 Natural 2 Accident	5 Pending	ation	(Month, Day	, Year)	injury	М	work'	Yes 2 🗆		8d. Describe	now inju	iry occurred	1		
Divisi tal or Att rs after d al Direct		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)						reet, factory, office 28f. Location (Stre- City or Town, S							or Rure	il Route Number,	
Division of Vital Rec To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Medical		Certifying Medical Ex Certifying		ge basis of ex	kamination	and/or inves	stigation, in	my opinio	n, death or	ccurred at 1	the time, date	and plac	e, and due	to the ca	ause(s) and manner	stated.
To with		29b. Signature and t	itle of certifier	K	1			290	c. License ) 2C	number 3	2		29d. D	te signed	(Month,	Day, Year)	
10		30. Name and addre	JHA	RUY	1/2/	772	n/	Print)	890	26 le	CeDy	mel !	24	1	IN	By M.	0
Stat Registra		31. Date filed (Month	n, Dāy, Year) 2010	Geneva	32. Registra	ar's Signat	ure	_									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1041 AM MIRACIE 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Balti more University of Maryland Med Ctr If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Min. Hours **Director** 5-2010 Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No Baltimore MD na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral U S 5537 Cedonia Avenue 21206 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates. Medical 15. Decedent's Education 16a Decedent's Usual Occupation na 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Shawntay ဂ္ Edward Kyler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Balto, MD 21206 Shawntay Ray -Mother 5537 Cedonia Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-31-2010|Baltimore, MDGreenmount March 21. Signature of Funeral Service Licenses 22. Name and Address of Facility East F/H Balto, MD 21202 E. North Avenue 1101 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ongenital disease or condition resulting in death) Medical Examiner Examiner Due to (or as a consequence of): 13 days Monic Stenosis Sequentially list conditions. Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Division of Vital Records, P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has been signed to completed filled in by the funeral director, page 2 should be determined. þ Intraventricular hemorrhage 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Superior Vena Cava Thrombosis 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) To the Hospital or Attending 1 🔀 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number July 18, 2010 ause of death (Item 23a) (Type, Print) S. greene S. Suite 104, Baltimore, MD 21201

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For
State
Registrar 23646 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July 25 Day 20 Th 9:45 Mary Russ Αм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cecil Union Hospital E1kton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Sept 16. 1 M 2 X F Hours Min. Massachusetts Director 1964 022-58-5148 Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Maryland or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Ceci1 MD E1kton 1 Yes 2 K No 10e. Street and Number 10f. Zip Code than "natural", or items 23a or 10g. Citizen of What Country? by Funeral with. 21922 USA 411 Maloney Road; Apt 1 Page 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şeconday (0-12) College (1-4 or 5+) unk waitress unk restaurant Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Joseph Coyle Sr. Nancy Pfeiffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Russ - husband 411 Maloney Road Apt 1; Elkton, Maryland 21922 permit. Page 1 and 2 Department of Healt Important: If item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury 4 Donation 5 Other (Specify) Signature of Funeral Services 22. Name and Address of Facility State Anatomy Board any Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest stock, or heart failure. List only one cause on each line.

Immediate Cause (Final Onset and Death Prosician/ Small disease or condition resulting in death) Non Medical Due to (or as a consequence of): Examiner Spine Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Other (specify) Month Dav Year Pregnant at time of death ed by the a detached f 9 Unknown Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 2 No 3 Probably 4 Unknown 1 X Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2, XNo certificate 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Linpatient 2 ER/Outpatient 3 DOA ျ . Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 5 Pending 1 Natural injury 2 🗌 No Accident Investigation Suicide 6 🗌 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number ☐ Homicide Cify or Town, State) Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year 25

State Registrar 31. Date filed (Month, Day, Year)

30-Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. R

			1 - State Registrar Amend Items	25,27,29a pe	r dr	triment of He 2905,07/29 Tificate of D	72010dhb eath	entai Hyt F	Reg. NO 1	0 23647
	Physici		1. Decedent's Name (First, Middle, Last	C. REA				2. Date of Dea Month		Year 2 10 A M
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Lo BACTIMO			4c. County o	f Death
	Funeral Director	Г	5. Social Security Number 6. Se.		last birthday) Yrs.	If Under 1 Year		B. Date of Birth (Month, Day	Year) 7	Birthplace (State or Foreign Country)
_	laryland show	ō	Usual Residence of Decedent  10a. State 10b. County		y, Town or Loc	*				10d. Inside City Limits 1 🛣 es 2 □ No
	death with the Maryland ims 23a or 28a-f show	Funeral Director	10e. Street and Number 405 S. Wickh	An Road		10f. Zip Code	129		10g. Citizen of Wh	
7e1	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examera, until by mailined at once.	by Funera		12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give I Year or Dates:		Vas Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Spec Mexican, Puerto R	ify Yes or No- ican, etc.)		American Indian, White, etc.
21215-0	l within 72 hu jiene. <b>r than "natu</b>	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give I	lent's Usual Occupati kind of work done dur DO NOT use retired) 20 CESSO	ring most of working	,	16b. Kind of Busin	iness/Industry · / C A C
) \	uld be filed Mental Hyg rked othei rtic event,	To Be C	17. Father's Name (First, Middle, Last) CARL Black			1	8. Mother's Name (		Maiden Surname,	
Merry Baltimore, Maryland	and 2 shoi ealth and N n 27 Is mailer traumailer traumaile		19a. Informant's Name/Relationship (7) RUBERT M. REA	JR.	405		cham f	Wad	BACTIA	WORE, MD 21219
$M\epsilon$	Pages 1 tment of H tant: If iter jury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	ETRO	sition (Name of later) CREMATOR	4 12	0/10	BACTIM	okt, M
Ball	Departiment any in once.		21. Signature of Funeral Service License		17	Name and Address	of Facility RE	DD Fac St, B	NERAL ALTIO, MI	None: > 2(217
4	Physician /Medical Examiner	050	23a. Part 1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	1ETASI	er the mode of dying,				Approximate Interval Between Onset and Death
	uted d ansit	Examiner	Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	uenoù of):					
9a 68760,	ficate be executed physician and s the burial-transit	ledical Exa	resulting in death) Last	Due to (or as a consequ	uence of):					
7, 29.	eath certi attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day Year
, 2	w requires that the d been signed by the should be detached	<u>م</u>	Part II. Other significant conditions cor	ntributing to death but not resu	ulting in the un	derlying cause given	in Part I.			oute to the cause of death?
$\pm 35$ , al Record	: The law re cate has ber page 2 sho	Completed						24a. Was a autop perfor 1 \( \textsquare\)	sy pri med? de	ere autopsy findings available for to completion of cause of lath? Yes 2 □ No
± √ Vital	Physician: The rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	fospital:		Othori	6. Place of Death	,		
ð		n: To	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury a	4 ☐ Nursing Hom		ence 6 Other ow injury occurred	, <u></u>
ion	ending ath. or: Aftu he fun	atio	1   Natural 5 ☐ Pending  Description  Natural 5 ☐ Pending investigation	(Month, Day, Year)	Injury	Work?	s 2□No			
Division	ital or Attending rs after death. al Director: After led in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office	28	f. Location (S City or Tow	treet and Number n, State)	or Rural Route Number,
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Att completely filled in by the fun	Medical	(Check only 2   Medical Examination one)	sician: To the best of my knowner: On the basis of examination and manner stated.	tion and/or inv	estigation, in my opin	nion, death occurre	d at the time, o	date and place, ar	nd due to the cause(s)
	viti Con	2	29b. Signature and title of certifier	Pand	ysicint ge					(Month, Day, Year)
_			30. Name and address of person who co	DY 4 MD	22	Print) Univer	Doole of St.	E MA	te mon	E MD 21201
	Sta Registra		31. Date filed (Month, Day, Year)  JUL 29201	32 egistrar's Signat	1. As	ules				./

		•	For State Registrar	State of Maryland		artment of He tificate of De			eg. N2 0 1 0	23648
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Dav Year	3. Time of Death
- Who	Medic Examin	al	MAGRUDER  4a. Facility Name (if not institution, give stre		ROBERT	SON 4b. City, Town, or Lo	ocation of Death	July	23 2010 4c. County of Deat	11:00a M
عر	LAGITIM		3138 Ellerslie Av	enue		Baltimo	ore		N/A	
	Funeral Director		5. Social Security Number  214-56-9072  Usual Residence of Decedent	7. Age (In yrs. la	V		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, AUG 6	Year) 9. Bir Co 1948 MAR	thplace (State or Foreign untry) YLAND
	land show dat	tor	10a. State 10b. County	10c. City	, Town or Loc	cation				10d. Inside City Limits
	Mary 28a-f	Director	MARYLAND N/A			BALTIM	10RE			XX Yes 2 □ No
	vith the 23a or st be r		10e. Street and Number	117		10f. Zip Code 21218		1	Og. Citizen of What Co	ountry?
	death vitems	Funeral	3138 ELLERSLIE AVEN 11. Marital Status 12	Was Decedent Ever in U.S	3. 13. V	Vas Decedent of Hisp Yes, specify Cuban,	panic Origin? (Spec	cify Yes or No-	14. Race - Ame	
Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ted by	1 ☐ Never Married 2 【XMarried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates.	1	☐ Yes 2XXIVo	Specify:	ioan, otoly	Black, White Specify: BLA	
15-	72 ho in "nat Medic	Completed	15. Decedent's Educi (Specify only highest grade	completed)	(Give k	ent's Usual Occupation  ind of work done dur  NOT use retired)		ng I	16b. Kind of Business	Industry
212	within /giene.		Elementary/Seconday (0-12) 12th grade	College (1-4 or 5+)		SERVICE			PRIVATE	
and	be filed ental Hy <b>ked oth</b> ic <b>event</b>	To Be	17. Father's Name (First, Middle, Last)			1	8. Mother's Name	(First, Middle, M. ROBINSO		
aryla	should be fil n and Mental 7 is marked or raumatic ev	.	RAYMOND ROBINSON  19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	a Address (Street and			City or Town, State, Zij	o Code)
ž	nd 2 st ealth a m 27 is ner trau		Ronald Robertson/H	usband	1	-			e, Marylan	
ore	ge 1 ar nt of Hu : If iten or oth		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Re	moval from State	emetery, crem	sition (Name of natory or other place)			20c. Location - City or	
ıltim	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other ance.		4 Donation 5 Other (Specify)  21. Sign up o Funeral Service Licenses	ME'		EMATORY  Name and Address	07-28		BALTIMORE,	
B	permi Depar Impol any ir		Malau C	5	I W	ILLIAM CRI 206 W NORT	ROWNERON	MUNITY	FUNERAL HO	ME P.A.
١,			23a. Part 1. Enter the disease, or complete shock, or heart failure. List only one of Immediate Cause (Final	tions that caused the death ause on each line.	n. Do not ente	r the mode of dying,	such as cardiac o	respiratory arre	st,	Approximate Interval Between Onset and Death
٥	Pnysician/ Medical		disease or condition resulting in death)	Due to (or as a Johsequ	ence of):	10W				
-	Examiner	<u>.</u>	Sequentially list conditions, b.	Schrzo	phr	cnia				
	ted nsit	Examiner	if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a contrequ	ente of):	W/Cora	les.			
P	ate be executed physician and the burial-transit		that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):	<u> </u>				
260	ate be chysici the bu	edical	d.							
687	certification programme as		IF FEMALE: 23b. Was decedent pregnant 23c	. If yes, outcome of pregnar		1			23d. Date of de	liverv
. Box 68	he death or y the atter iched for u	Physician/M	in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown	1 Live Birth 2 Fetal 4 Pregnant at time of d 9 Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions control	buting to death but not resu			n in Part I.		oacco use contribute to es 2 <b>⊠</b> No 3□ P	the cause of death?
cord	law req las bee	Completed						24a. Was ar autops	y prior to	topsy findings available completion of cause of
Re	n: The ficate h		25. Was case referred to medical			00.00	(D. 11.10)	perform	ned? death?	3 2 No
Vita	ysiciar is certii directo	To Be	evaminer?	pital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatien	Other	e of Death (Check		nce 6 Other (Spec	ify)
n of	nding Ph th. : After thi e funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury a work?			w injury occurred	
ivisio	il or Atter after des Director d in by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)		eet, factory, office	2	28f. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,
ш	e Hospita 24 hours e Funeral pleted fille	Medical	(Check 2   Medical Examiner	n: To the best of my knowle On the basis of examination ractioner: To the best of my	and/or invest	igation, in my opinion,	death occurred at	the time, date and	d place, and due to the	cause(s) and manner stated.
•	To th within To th comp	-	29b. Signature and title of certifier	5 M	D	29c. License n			9d. Date signed (Month	
	7		30. Name and address of person who com	oleted cause of death (Item	23a) (Type, P	rint) Ra	a VM	BIVd	Balki	10 21239
E	Stat Registra		31. Date filed (Month, Day, Year) JUL 29 2010 Leve	32. Registrar's Signat						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 29 State of Maryland Deportment of Health and Mental Hygiene For State Registrar Certificate of Death No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 20°10 9:30 PM William Rode Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care - Lochearn Baltimore Social Security Numbe . Age (In vrs. last birthday if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) UNK **Funeral**  $Feb 21^{Day}$ 1 🖾 M 2 🗆 F Months Days Hours Min. Director 85 213-20-8446 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Maryland notified at 10d, Inside City Limits Director Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Examiner must be Funeral 23a 21216 USA 4012 Bateman Avenue items Page 1 and 2 should be filed within 72 hours after death 11. Marital Statusunk 12. Was Decedent Ever in U.S. unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō þ 1 Never Married 2 Married 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify. If Yes, Give "natural" Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation UTIK
(Give kind of work done during most of working Medical 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) r than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene. tem 27 is marked other tha Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) $\mathrm{unk}$ 18. Mother's Name (First, Middle, Maiden Surname) unk 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4800 Seton Drive; Baltimore, Maryland 21215 Future Care - Lochearn item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🛣 Other (Specify) in state = Department of Important: If any injury or once. 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 of Funeral Service Ron 111 Signati Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) therosclopotic Ph sician/ month Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examiner If any, leading to immediate cause. Enter Underlying Due to for as a consecuence of Cause (Disease or linjury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No g Unknown the detached 9 Unknown Division of Vital Records, P.O. ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 🗆 No funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 D-Nursing Home 5 Residence 6 Other (Specify) ဂ္ဂ 2 W/N0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred : After t 1 Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 흐 29c, License number 29d. Date signed (Month, Day, Year)

Registrar

**State** 

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SAZTIMONE, MD

<del>67</del> July 12, 2010

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ PILEY Sabrina 1225 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □√F Hours 02/01/1987 219-13-4311 Maryland Director Jsual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amp injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 ¥ Yes 2 □ No MD N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 529 South Fulton Avenue 21223 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Completed by 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Linda Lou Hines Dirk Jerome Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda L. Riley (Mother) 2741 Wilkens Avenue, Baltimore, Maryland 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 07/28/2010 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. shock, or heart failure. List only one cause on each line Immediate Cause (Final encephalop athy Physician. anotic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner nunging Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Jun to (or as a nunsiliquence of) Physician: The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ξ in the past 12 months? Year Month Day 5 Other (specify) the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Dzp1255 10in 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director; After this certifica completed filled in by the funeral director, I 25. Was case referred to medical examiler?

1 2 Yes 2 No Be 26. Place of Death (Check only one) Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending ☐ Natural 5 Pending 2 🗹 No hanging 2010 6:40 1 🗌 Yes 2 Accident 3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5. Fullon Ave Ballimore MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined At home Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 100541 mo 24 2010 erson who completed cause of death (Item 23a) (Type, Print)

State Registrar 30. Name and address 🌽

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32. Registrar's Sig

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Battimore

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Wear Medical **Examiner** cility Name (if not institution, give street and number) Mar If Under 1 Year If Under 24 8. Date of Birth 9. Birthplace (State or Foreign Hrs. **Funeral** 1 □ M 2 🖾 F Months Hours Min. Maryland Director 219-22-7699 84 Usual Residence of Decedent or items 23a or 28a-f show miner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d Inside City Limits Director 1 Yes 2X No Baltimore Pikesville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21208 4202 Old Millford Mill Road 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, the Medical Examiner Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 21 No Specify. 3 Widowed 4 K Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) paint manufacturing laqueur chemist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o Augustine Constantine Radziszews Helen Pluciak permit. Page 1 and 2 shoul Department of Health and I Important: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Priscilla M. Rieger - friend 6345 Loring Dr; Columbia, Maryland 21045 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State ò ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 Other (Specify) any injury 22. Name and Address of Facility State Anatomy Board Signature of Femeral Service 655 W. Baltimore St; Baltimore, Maryland 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.) Examine Due to or as a consequence of as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death signed by the a 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perforn death? eral Director: After this certificate filled in by the funeral director, pag 25. Was case referred to medical noatron B 26. Place of Death (Check only one) examiner? ᇛ Other: 2No 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and th 29d. Date signed (Month. 3100

State Registrar 31. Date filed (Month, Da

of death

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Reastrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ _2010 Year 1:38 P M Ann M. Snow July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Towson 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Germany 1 □ M 2 😾 F Days Hours March Day Ye Director 116-38-9179 63 T947 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified and once. 10a. State 10b County 10c. City. Town or Location 10d Inside City Limits Director MD Baltimore Timonium 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2441 Springlake Dr. 21093 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: white Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) 12 Healthcare Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Augustinas Elizabeth Kursulis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert Kenneth Snow/husband 2441 Springlake Dr., Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 7/30710 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans Cem. Garrison Forest, MD Signature of Emeral Service Licens 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Michael flagle Part T. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1. Enter the disease Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ LEIDMYDSARCOMA OF UTERUS
Due to (or as a consequence of): 2007 disease or condition Medical resulting in death) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death the page 2 should be detached Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has autopsy 2 🗌 No 1 Yes Yes Be 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🛣 No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 📈 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural work? injury 5 Pending s after death. Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. 29b. Signature and title of certifier 164395

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DHMH 17 Rev 7/2009

Registrar

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NOMARLES ST, SMITE 4105 BALTIMARE, ND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOBONNAN MO

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#3, 24a&26perPHYS, G905, 7729/2010, WS&#2

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 07-24-2010 July 22, 2010 1. Decedent's Name (First, Middle, Last) 3 Time of Death Physician/ 18:20pm ^M DAGOBERTO O. SAAVEDRA Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner RINCE GEORGE's PRINCE GEORGE HOSPITAL CHEVERLY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗷 M 2 🗆 F Months Days Hours 1939^{Country)} Salvador December 70 613-18-6620 **Director** Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 1 Yes 2 ☐ No Hyattsville Maryland Prince Georege's 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20781 El Salvador 5506 Hamilton St Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☑ Yes 2 ☐ No Specify: Salvadorian White If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Store Maintenace/janitor 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ PEDRO SAAVEDRA JUANA OLIVA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HECTOR DAGOBERTO SAAVEDRA (Son) 5605 Hamilton ST, Hyasttville, 20781 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a Method of Disposition cometery, crematory or other place)
Municipal San JuanOpico8/8/2010 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State San Juan Opico 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Santa Cruz Funerales Latinos, Inc. 600 Kennedy ST, NW: Washington, DC 20011 Signature of Funeral Servi 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ mult disease or condition resulting in death) Medical Due to (or as consequence f) Examiner bacterenic negative Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events adder Cance the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 signed by the attending pages as a signed for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy Yes 2 X No certificate within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 NO 1 Yes 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 27. Manner of Death Certificate: 28d. Describe how injury occurred iniury Natural 5  $\square$  Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) 0843665 Tuly 25, 2010

Registrar DHMH 17 Rev 7/2009

State

rack

G Horbita

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BUYER

William 31. Date filed (Month, Day, Year)

		4	For State	State of	Maryland		irtment of H <i>tificate of D</i>	ealth and N leath		2.0	10	23655
			Registrar  1. Decedent's Name (First, Middle, L.	ast)	,	007	incate or D	Calif	2. Date of Dea	Reg. No.—		3. Time of Death
	nysicia: Medic	al .	Romain	p 54	ein				Mily	25 2	0%	//SAM
) E	xamin	er	4a. Fadlity Name ( <i>if not institution, gi</i> 3605 Brooklyn		er)		4b. City, Town, or	Location of Death imore		4c. County	y of Death	
Fu	ıneral		5. Social Security Number 6.	Sex 7	. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt	h	g. Birthpla	ace (State or Foreign
	ector		220 38 8074 Usual Residence of Decedent	1 □ M 2 🖾 F	68	Yrs.	Months Days	Hours Will.	09707	<u>71941                                   </u>	Mary	/land
and	show 1 at	ō	10a. State 10b. County		1	Town or Loc					10	d. Inside City Limits
Mary	28a-f notifie	Director	Maryland N/A			Baltim		· · · · · · · · · · · · · · · · · · ·				1 X Yes 2 □ No
/ith the	23a or st be r		10e. Street and Number 3605 Brooklyn	Avenue			10f. Zip Code	1225		10g. Citizen of U.S	What Countr	ry?
leath v	items er mu	Funeral	11. Marital Status	12. Was Deced		. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No- Bican, etc.)		ce - America	
after	al", or xamin	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1  Yes If Yes, Give	2 🔀 No		Yes 2 No		, , , , , , , , ,	Specify	ck, White, et	ite
2-0050	natura Jical E	Completed	15. Decedent's		es.		ent's Usual Occupa		ina	16b. Kind of E		
hin 72	than "	Ĭ,	Elementary/Seconday (0-12)	College (1-4	1 or 5+)	Ìife. DC	NOT use retired)		ing	Custod	ian /	St. Johns
IG NI led wit Hygie	other ent, th	as l	17. Father's Name (First, Middle, Last	;)		пос	ise Crean	18. Mother's Nam	e (First, Middle,			
Viand Id be filed Mental Hy	arked atic ev	유		Henry E	llicott	•			Edna Ro	bey		
2 shoulth and	7 is m trauma		19a. Informant's Name/Relationship			i	g Address (Street a					
and 2	item 2		Darlene Davis / D 20a. Method of Disposition	augnter	20b. Pl	ace of Dispos	Brooklyn sition (Name of		Dall	20c. Location		nd 21225 vn, State
altimo	ant: If		1 ☐ Burial 2 🛣 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		, acc		natory`or other place rematory	07/2	7/2010	Baltim	ore, M	Maryland
Datitinore, Maryland 41213-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.	Importa any inju once,		21. Signat of Fineral Service Live	Mari	Dae	22	Name and Addres	s of Facility Go	nce Fun	eral Se timore.	rvice, Marvl	P.A. land 21225
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that ca	used the death						7-	Approximate Interval Between
	ician/		Immediate Cause (Final disease or condition	_ a C	o/on	Co	ence	1				Onset and Death
	edical miner		resulting in death)	Due to (o	r as a consequ	ence of):	9					
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (o	r as a consequ	ence of):						
ecuted	and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (o	r as a consequ	ence of):						
be exe	physician and the burial-transit	dical	resulting in ocally cast	<b>d</b> .								
ertificate b	ng phy as the		IF FEMALE:									
death cer	attendi for use		23b. Was decedent pregnant in the past 12 months?			death 3	Ectopic pregnanc Other (specify)	y			ate of deliver onth [	ry Day Year
the de	by the ached	hysi	1 ☐ Yes 2 💆 No 9 ☐ Unknown	g 🔲 Unkno	own							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	signed Id be del	Completed by F	Part II. Other significant conditions	contributing to de	ath but not resu	ılting in the u	nderlying cause giv	en in Part I.				e cause of death?  ably Unknown
VILAI RECORUS, ysician: The law requires	as beer 2 shou	plete							24a. Was			sy findings available apletion of cause of
The	cate h								perfo	rmed?	death?	2 No
sician	rector	m	25. Was case referred to medical examiner?  1 ☐ Yes 2 ► No	Hospital:	npatient 2 🗆	EP/Outpotion	Othe	r: 4 Nursing Ho		donos 6 🗆 Oth	or (Specify)	
o Phy	ter this neral d	te: To	27. Manner of Death  1   → Natural 5   ☐ Pending	28a. Date o		28b. Time of injury	28c. Injury work	at	28d. Describe h			
tendir death.	tor: At	Certificate:	2 Accident Investigat 3 Suicide 6 Could no	the	of Injune At hor	ma form of		Yes 2 □ No	205 1	Street and Numb	har ar Bural i	Pauta Numbar
al or Attending P	il Direction by		4  Homicide determine		g, etc. (Specify)		set, factory, office		City or Tow		Jer or riarari	loate Hambol,
Hospit 24 hour	Funera sted fille	Medical	(Check 2 Medical Exa	miner: On the basis	s of examination	and/or invest		n, death occurred a	t the time, date a	and place, and di	ue to the caus	se(s) and manner stated.
To the within	To the		only one) 3 L. Certifying N 29b. Signature and title of certifier	urse Practioner: I	the best of my	knowledge, d	leath occurred at the 29c. License			29d. Date signe		
	•		· Cour	10	h_	(1)	01	587	2	July	26,	Zon
6	V		30. Name and address of person wh	o completed cause	of death (Item	23a) (Type, P	Wins &	in BI	m	Sund	pa	216/
	Stat		31. Date filed (Month, Day, Year)	32. Re	ostrar's Sapa	Mad						

			State Registrar		Cer	tificate of D	Death		Reg. No.			
	Physicia		1. Decedent's Name (First, Middle, Las	Josephine Vir	oinia	Sebra		2. Date of Dea Month	th Day Year 24 20/1	3. Time of Death		
	Medic Examin		4a. Facility Name (if not institution, give	street and number)	811110	4b. City, Town, or		1	4c. County of De			
 377	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.)	last birthday)	If Under 1 Year Months Days	MOY E  If Under 24 Hrs.  Hours Min.	8. Date of Birt	N/A	Birthplace (State or Foreign		
H	Director		218 42 8960 1 1 Usual Residence of Decedent	□ M 2 🕱 F 66	Yrs.	Wonth's Days	Hours Will.	(Month, Day 05/28	71944 M	aryland		
	yland f show ed at	ţō	10a. State 10b. County		ty, Town or Loc					10d. Inside City Limits 1 ☐ Yes 2 🛣 No		
	r 28a- notifie	Dire	Maryland Anne	Arundel	Baltim	10f. Zip Code		— Т	10g. Citizen of What (			
	with th	Funeral Director	102 E. 11th Ave	enue			1225		U.S.A.			
	r death ir items iner m	y Fun	11. Marital Status	12. Was Decedent Ever in U. Armed Forces? 1  Yes 2 No		Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.		
903	ırs afteı ural", c	ed by	3 X Widowed 4 Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2 🗓 No	Specify:		Specify:	White		
15-(	72 hou in "nati Medica	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Give I	lent's Usual Occup kind of work done o O NOT use retired)	ation during most of wor	<i>kin</i> g	16b. Kind of Busines	ss Industry		
212	within /giene. <b>ner tha</b> t, the [		Elementary/Seconday (0-12) 9th	College (1-4 or 5+)	Sec	urity Gu				ng Company		
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland ental Hygiene. 'ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)	Clarence Myers	S			ne <i>(First, Middl</i> e, . <b>therine</b>	Maiden Surname) Wilds			
lary	should be file h and Mental I 7 is marked o raumatic eve		19a. Informant's Name/Relationship (1	••	- 1				; City or Town, State, .			
e, S	1 and 2 s of Health of item 27 i		Judy Green / Data	20b.	Place of Dispo	E. 11th A		Baltimo	ore, Maryla			
mor	Page 1 ment of ant: If it ury or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	cemetery, cren	natory or other place en Mem. P	/	28/2010	•	nie, Maryland		
Balti	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of tine al Service Licen									
.*	£		23a. Part 1. Enter the disease, or comshock, or heart failure. List only of	est,	Approximate Interval Between							
	Ph _{sician/} Medical	3 4	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseq					,	Onset and Death		
	Examiner	_	Sequentially list conditions,	Abdomi	nal	Visco	is per	for a	tion	01 day		
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	tificate be executed ng physician and s as the burial-transit	al Exa	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):							
8760	icate b g physic is the b	Medical		d								
89 ×	ath certif attending I for use a		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn.	al death 3	Ectopic pregnand Other (specify)	СУ		23d. Date of o	delivery Day Year		
P.O. Box	the dea by the a ached f	Physician/	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	dealii 5 L	Unier (specify) _						
s, P.C	requires that the de been signed by the should be detached	d by P	Part II. Other significant conditions of Hyperlen	500n	sulting in the u	inderlying cause giv	ven in Part I.			to the cause of death?  Probably 4 Unknown		
cord	e law requ	Completed by	Hypotin	midism				24a. Was	osy prior t	autopsy findings available to completion of cause of		
Be	The licate h		Dement: 25. Was case referred to medical	9		00 01	leas of Dooth (Cha	1 🗆 Yes	rmed? death	Yes 2 No		
Vita	ysiciar s certii directo	To Be	examiner?  1 \( \sum \) Yes 2 \( \sum \) No	Hospital:	ER/Outpatier	Oth	er: 4  Nursing F		lence 6  Other (Sp	pecify)		
Division of Vital Records,	nding Phy ath. : After thi e funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injur work		28d. Describe h	ow injury occurred			
Division	al or Atte s after des I Director d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		ome, farm, str	eet, factory, office		28f. Location (S City or Tow	Street and Number or I rn, State)	Rural Route Number,		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Exam	vsician: To the best of my knowniner: On the basis of examinationse Practioner: To the best of m	on and/or inves	tigation, in my opinie	on, death occurred	at the time, date a	nd place, and due to th	ne cause(s) and manner stated.		
	To the within com		29b. Signature and title of certifier	soft n	D	29c. Licens	e number 240 <i>5</i> ·	8	29d. Date signed (Mo July 2	10th, Day, Year)		
_	31		30. Name and address of person who A GEGNEHU 7	completed cause of death (Itel	n 23a) (Type, F	TASNES	Hosput	al,900	Caton A	ve, Baltimon		
	Star Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signa	aturé	I	,					

SEBRA, JOSEPHINE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Curtis Dean Sparkman 1:00 A.M 2010 Ju1v Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Ceci1 Union Hospital E1kton 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 ☐ M 2 ☐ F Hours M3738/1948 Mar∜land 216 50 2245 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 28a-f shor 10d. Inside City Limits event, the Medical Examiner must be notified at Director Maryland Ceci1 Rising Sun 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Funeral 23a 21911 U.S.A. 456 Lombard Road items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 0 2 1 Never Married 2 Married Yes 215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced White Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self employed Construction 10th and Mental Hygie is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ild be file Mental F ည Curtis Sparkman Marguerite Groover Important: If item 27 is marke any injury or other traumatic it. Page 1 and 2 should be artment of Health and Menortant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marydel, Maryland 21649 26960 Fueller Drive Sherry Hayden / Sister Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 KCremation 3 Removal from State Bayview Crematory 08/02/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a, Part 1, Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Ca disease or condition Medical resulting in death) Examiner bone Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death the i signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s perform certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To I 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 1 Natural 8c. Injury at 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and 29d. Date sig 005644 Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signat Date filed (Month, Day, Year State

Registrar

Registrar
DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryla		rtment of He tificate of De			giene 0	10	23659
	Physicia		1. Decedent's Name (First, Middle, Las	Taltys				2. Date of De Month	ath Day	Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or L			1	ty of Death	3/10/7
	Funeral		5. Social Security Number 6. Se		s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir		9. Birthp	lace (State or Foreign
	Director		212-48-6706 1 Usual Residence of Decedent	<b>M</b> M 2 □ F	63 Yrs.	Months Days	Hours Min.	May 6,	^{y,} 1947	Mary	l'and
	yland -f show ed at	ctor	10a. State 10b. County		City, Town or Loc	ation				10	0d. Inside City Limits
	the Mar or 28a e notifi	Dire	MD Balti 10e. Street and Number	more		10f. Zip Code			10g. Citizen o	f What Coun	1 🗌 Yes 2 🖾 No try?
	ith with ms 23a must b	Funeral Director	1516 Taylor Ave		us Lieu	21234			USA		
9000	ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in the Armed Forces?  1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates.	1967 <b>–</b> If	as Decedent of Hisp Yes, specify Cuban, ☐ Yes 2 🏻 No	, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - America ack, White, e fy: Whi	etc.
15-(	i 72 hou in "nati Medica	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give k	ent's Usual Occupat ind of work done du NOT use retired)	ion ring most of work	ing	16b. Kind of	Business Ind	lustry unk
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land	l be filed fental Hy rked oth ifc event	일	17. Father's Name (First, Middle, Last)  John A. Taltys			1	18. Mother's Nam Agnus I	e (First, Middle, Frankows		ne)	
Mary	should be fil n and Mental 7 is marked or raumatic eve		19a. Informant's Name/Relationship (Ty John Taltys – b			Address (Street an			-		'
re,	1 and 2 s of Health item 27 other tra		20a. Method of Disposition	20b	. Place of Dispos			Date	20c. Location		
Baltimore, Maryland 21215-0036	t. Par tmer tant ijury		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Noticer (Specify	in state		atory or other place)					
Ba	Depar Depar Impor any ir	5	21. Support of Funeral Service Licens	a Ditecto		Name and Address 655 W. Ba					MD 21201
×.	Pnysician/ Medical Examiner	er	23a. Part 1. Enter the disease, or comp. shock, or heart failure. List only or Immediate Cause (Final disease or comition resulting in death)  Sequentially list conditions, if any, leading to immediate	lications that caused the dele cause on each line.  a. Due to (or as a conse	equence of):	the mode of dying,	such as cardiac o	or respiratory ar	rest,	- 1.	Approximate Interval Between Onser and Death
092	as that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	edical Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	cDue to (or as a conse							
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. within 24 hours after death. completed by the attending completed filed in by the funeral director, page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1  Live Birth 2 Fe 4  Pregnant at time of 9 Unknown	etal death 3 🔲	Ectopic pregnancy Other (specify)			1	Date of deliver	ry Day Year
ds, P.C	v requires that to been signed be should be deta	þ	Part II. Other significant conditions co	ntributing to death but not r	resulting in the un	derlying cause giver	n in Part I.				e cause of death?
Division of Vital Records,	sician: The law re s certificate has be lirector, page 2 sh	Completed	25. Was case referred to medical					1 🗆 Yes			sy findings available npletion of cause of 2   No
Vita	Physiciar this certii ral directo	To Be	overniner?	Hospital:	☐ ER/Outpatient	Other:	e of Death (Check		lence 6 🗆 Ot	her (Specify)	
ion of	To the Hospital or Attending Physician: within 24 hours after deals,  To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of injury (Month, Day, Year)	28b. Time of injury		es 2 🗆 No	28d. Describe h			
Divis	tal or Airs after or Direct		4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		et, factory, office		28f. Location (S City or Tow		ber or Rural f	Route Number,
	To the Hospital within 24 hours a To the Funeral ( completed filled	Medical	(Check 2 Medical Examination only one) 3 Certifying Nurs	ician: To the best of my kno ner: On the basis of examinat e Practioner: To the best of	tion and/or investig	gation, in my opinion, eath occurred at the t	, death occurred at ime, date and place	the time, date a	nd place, and d	ue to the caus	se(s) and manner stated.
D	vit Sol		29b. Signature and title of certifier	ompleted cause of death (Ite 3900 Lack) 32. Registrar's Sign	0.	29c. License n	59 (OF	(0)	29d. Date sign	ad (Month, D	Pay, Year)
		,	30. Name and address of person who co. Tokus, Lak, m.D.	Spoo Lard	em 23a) (Type, Pr Caven R	erileinand	Baltin	on Ma	Mount	2121	8
Ē	Stat Registra		31. Date filed (Month, Day, Year)	32. Reg Strar's Sign	nature		7	(			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 19^{Day} Physician/ 20°f'0 July 2:18 Рм Edmund Francis Troy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium Stella Maris 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Aug 20, Year) 927 1 🔀 M 2 🗆 F Months Days Hours Min. Maryland 218-22-2497 82 Director Usual Residence of Decedent 28a-f shov ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3939 Roland Avenue #215 21211 USA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? 1943 If Yes, specify Cuban, Mexican, Puerto Rican, etc. by 1 X Never Married 2 Married P.M. Maryland 21215-0036 Specify: white If Yes, Give 1 Yes 2 No Specify: 1947 Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) retail food general manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anna Henrietta Mueller William John Troy and 2 should be Health and Ment 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 5043 E. Oak Point Dr; Prior Lake, MN 55372 George F. Troy - brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other placel 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 Di Other (Specify) in state 21. Sign turn I Euneral Serv 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Cereb. Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami requires that the death certificate be executed Cause (Disease or linjury and -tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical EDMUND TROY JULY 19, 2010 Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Dav Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has I page 2 s To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Tyes / 2 / No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🗮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar DULANEY VALLEY ROAD

TIMONIUM, MD 21093

2010

J. Mo.

2300

egistrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT MOSS, M.D.

31. Date filed (Month, Day, Year)

		For State Registrar	State of	Marylan	id / Depa <i>Cen</i>	rtmer	nt of H e of D	ealth an eath	nd Me	ental Hy	giene Reg. No	2010	)	23661
Physicia	n/	1. Decedent's Name (First, Middle,	,						2	2. Date of Dea			r	3. Time of Death 2:05 P M
Medic Examin		FRANK TACHA 4a. Facility Name (if not institution,	give street and numb	per)				Location of D	Death	UULT	$\neg$	. County of De	eath	
Funeral		,	6. Sex 7	. Age (In yrs. I		If Under		If Under 24 I	Hrs. 8	B. Date of Birt	th v YearL		ARRI Birthpla	ace (State or Foreign
Director ≥		354-24-3923 Usual Residence of Decedent	1 <b>X</b> M 2 □ F	80	Yrs.		Bayo	Tiours	1	10/19/	1929			GERMANY
faryland 3a-f sho tified at	Director	MD CARRO	)LL	10c. Cit	y, Town or Loc		SVIL	LE					10	d. Inside City Limits 1 ☐ Yes 2XXNo
vith the N 23a or 29 st be no	ral Dir	10e. Street and Number 7200 3RD AVENUE	E, APT.C-1	7		10f. Zip	Code	2178	34		10g. Ci	tizen of What	Countr	y?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 🂢 Marr		ces? 2 🗌 No	If	Yes, spec	cify Cubar	panic Origin? , Mexican, Pu	? (Specif uerto Ric	fy Yes or No- can, etc.)		14. Race - Ar Black, Wi	nite, et	c.
nours aft latural", ical Exal		3 ☐ Widowed 4 ☐ Divorced  15. Deceden	If Yes, Give Year or Date t's Education		16a. Decede			Specify:			16b K	Specify:		I TE
ithin 72 h ene. <b>r than "r</b> t <b>he Med</b> i	Completed	(Specify only higher Elementary/Seconday (0-12)	completed) College (1-4	1 or 5+)	(Give k	ind of wo NOT use	rk done di e retired)	uring most of	f working	7		ITICAL		•
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2 should th and Me 27 is mar traumati		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailing	g Address	Street a	nd Number or UE . APT	or Rural F	Route Numbe	r, City or KES V	Town, State,	Zip Co MD	21784
ge 1 and nt of Heal : If item ? or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from S	State	Place of Dispos cemetery, crem	atory or o	ne of other place	e)	Da	te	20c. L	ocation - City	or Tow	n, State
permit. Pa Departmer Important any injury once.		4 Donation 5 Other (S ₁	, ,	JBAL	TIMORE 22.	Name an	nd Address	s of Facility S	SOL 1	LEVINS	ON 8	BROS.	, I	NC.
<u>40</u>		23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that ca	used the deat								ILLE,		Approximate
Physician/ Medical		snock, or near failure. List of Immediate Cause (Final disease or condition resulting in death)	- a M1	r as a consequ	ple	M		oma					1	Interval Between
Examiner	er	Sequentially list conditions,	b. ———				•						_	v
cuted ind transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	с	r as a consequ										
ate be executed physician and the burial-transit	dical E	resulting in death) Last	d	r as a consequ	derice oi).									
eath certifica attending ph I for use as th	ıoı	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregna		Ectonic	pregnancy	,				23d. Date of	deliver	у
the death by the att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ant at time of		Other (s)						Month		Day Year
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi		Part II. Other significant condition	ns contributing to dea Luve_	ath but not res	sulting in the ur	nderlying	cause give	en in Part I.		23e. Did to				cause of death?
law require has been si e 2 should t	Completed by	type I c	Licbetes							24a. Was autor		24b. Were prior t	to com	sy findings available pletion of cause of
sician: The law is certificate has t	Be Co	25. Was case referred to medical examiner?					26. Pla	ce of Death (0	(Check o	1 🗌 Yes			Yes 2	P. □ No
Physic this ce	욘	1 ☐ Yes 2 ☐ No  27. Manner of Death	Hospital: 1 Ir 28a. Date o		ER/Outpatient		OA Othe	4 Nursir		e 5 🗆 Resid		Other (Sp	ecify)	
tending leath. :or: After the fune	Certificate:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could r	ation (Month	, Day, Year)	injury	М	work?	res 2 No	0	_				_
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,		4  Homicide determi	ned 28e. Place of building	g, etc. (Specify						City or Tow	vn, State	)		Route Number,
ne Hosp in 24 hor ne Fune pleted fi	Medical	(Check 2 ☐ Medical Ex	Physician: To the be- caminer: On the basis Nurse Practioner: To	of examination	n and/or investi	gation, in	my opinior	n, death occur	rred at th	ne time, date a	and place	e, and due to th	ne caus	se(s) and manner stated
Voithi Com		29b. Signature and title of cellrife	LMD			290	D 3	number 484	.Cj		29d. Da	te signed (Mo	nth, Di	ay, Year)
4V		30. Name and address of person v	who completed cause	of death (Item	1 23a) (Type, Pr	rint)	z R	3 6.	ld	lersbu	ws.	MD	2	1784
Stat Registra		31. Date filed (Moeth, Day, Year)	V)	gistrar's Signa	barks?	,	-							

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Amend Item 26 per verb., 8905, 08/17/2016 Ensure All Copies Are Legible.

Amend Item 26 per verb., 8905, 07/19972019 and Mental Hygien Certificate of Death 23662 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** PATRICIA 10:35 AM JOYCE 2010 July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6603 Reliance Road Federalsburg Caroline If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2**X** F 68 Yrs 220-38-8277 11/16/1941 ŃΥ Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show be notified at MD Caroline Federalsburg 1 ☐ Yes XXNo Director 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 3800 Federalsburg Highway 21632 USA 23a Examiner must Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 'natural", or items 11. Marital Status of fled within 72 hours after de Hygiene.

Other than "natural", or item Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White þ 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur. any injury or other traumatic event, the Medical once. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Nursing Assistant Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thelma Evelyn Barrett Joseph Philip Thweatt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Pamela Ford/Daughter 2041 Knotty Pine Drive, Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Final Journey Crem. 7/28/2010 Woodbine, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Naryland Cremation Services

Maryland Cremation Services Mashall PO Box 1413, Baltimore, MD 21203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Uterine Papillary Serous Carcinoma** Approximate no.
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) Cervien 2 mos **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in arry, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for sels nuneaquenne offi Examine physician and s the burial-trans Due to (or as a consequence of): Physician/Medical use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown þ cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 √0 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No. 24a. Was an autopsy performed?

1 Yes 2 No certificate After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Son's Other: 4 Nursing Home 5 Residence 1 Yes 2 No 6 Other (Specify Residence ၉ 1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. 2 Accident Director; / 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Ain 24 hours and othe Funeral Direct 4 Homicide 29a. Certifier 1 💢 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 July 26, 2010

0

Records,

Division or Vital

State

30. Name and addre

Michael

AUC Hurlock Mc 21643

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 0 0

			For State Registrar	Otato or ma	i yidirid / s	Certificate of		F	Reg. No.			
30	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, L. Columbus 4a. Facility Name (If not institution, gi			Thoma 4b. City, Town	, or Location of Dea	2. Date of Dea Month	24	2010 ounty of Death	3. Time of Death	
1	LXaiiii	le i	The Johns Hopkins I		(In yrs. last bir	Baltimo		rs. 8. Date of Birtl		N/A	place (State or Foreign	
Ľ	Funeral Director		248-32-5359	1 XM 2 □ F	- 1	Yrs. Months Day			, Year)	Cour	ITH CAROLIN	
	rland		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City Limits	3
	Ba-f sh tified a	ector	MD. N/A		BA	LTIMORE					1 X Yes 2 □ No	)
	th with the 23a or 2 st be no	Funeral Director	1400 E. MADISON	ST.		10f. Zip-Code	L205		-	n of What Cour USA	ntry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatht and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Co		(Specify Yes or No- rto Rican, etc.)	1	. Race - Americ Black, White, pecify: BL		
21215-0036	"natur dicai f	Completed	15. Decedent's (Specify only highest g	rade completed)		Decedent's Usual Occ (Give kind of work do- life. DO NOT use reti	ne during most of w	rorking	16b. Kind	of Business/Ir	ndustry	
212	d withir giene. r than the Me	comp	Elementary/Secondary (0-12)	College (1-4 or 5+	·)	PLASTER	160)		C	ONSTRUC	TION	
Maryland 2	ould be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Las HOWARD THOMAS				MINN	iame (First, Middle, IE THOMAS	3			
Mar	id 2 should the and 27 is m		19a. Informant's Name/Relationship  MARVIN THOMAS (S		196	2517 LINWO					,	
	es 1 and of Health i item 27 r other tr		20a. Method of Disp scition	Removal from State	20b. Place o	of Disposition (Name of ery, crematory or other p		Date		tion - City or To		
Baltimore,	t. Pages rtment of I rtant; if ite		4 Donation 5 Other (Spec	rify)	RBUTI	US MEMORIAI	PARK 7-	29-2010	BALTI	MORE,	MARYLAND	
Bal	permit. Departri Importa any inju		21. Signature of the art Service inc	VIAN TANOL		NER ^{2.} Name and Add					TAMD 21217	
			23a. Part 1. Eter the disease, or conshock of heart failure. List only	inplications that caused to one cause on wich line	he death. Do	not enter the mode of o	dying, such as card	iac or respiratory ar	rest,	· MANI	Approximate Interval Between	
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68760,	fficate I g physi as the	Medical		_ d								_
). Box (	t 5 0	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o  1  Live birth 2  4  Pregnant at ti 9 Unknown	2 Fetal death	3 Ectopic pregna 5 Other (specify)	ancy		230	d. Date of deliv Month	Day Year	
rds, P.O.	r requires that the death ce been signed by the attendii should be detached for us	by	Part II. Other significant conditions	contributing to death bu	t not resulting	in the underlying cause	given in Part I.	23e. Did to			the cause of death? bably 4 \( \subseteq \text{Unknown} \)	ı
		Completed						24a. Was a autop perfor 1  Yes	sy	24b. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of	,
<b>Vita</b>	Physician: The land this certificate has rail director, page	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	t 2 🗆 ER/Ou	utpatient 3 DOA	Othor:	eath <i>(Check only or</i> Home 5 $\square$ Resid		Other (Specific	5.1	_
οl	Phys this ral d	n: To	27. Manner of Death	28a. Date of Injury (Month, Day)	28b.	Time of 28c. In		28d. Describe h			y)	_
Sion	l or Attending Phyafter death.  Director: After this in by the funeral	ertification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	on		M 1	☐ Yes 2 ☐ No	20f Location /6	`troot and i	Alumbar or Due	al Route Number,	- 1
Σ	F # F C	O	4 - Homicide determined	building, etc.	(Specify)	rm, street, factory, offic		City or Town	n, State)			12
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical		hysician: To the best of aminer: On the basis of and manner state	examination an							
	To the vithin comp	Ž	29b. Signature and fittle of certifier			29c. Lice	nse number		29d. Date s	igned (Month,	Day, Year)	
	りく		30. Name and address of person who	completed cluise of de		(Type, Print)	600	North Wo	lfe St,	Baltimo	re, MD, 2128	7
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 29 2010	32. Registrar	s Signature					-		
DHI	MH 17 Rev 1/2	ากา	AAP AA COID	anno G.	gara							_

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23664 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jean Tiffany 11:30 PM 2010 July 22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Harford Harford Memorial Hospital Havre de Grace Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthdav) **Funeral**  Date of Birth (Month, Day, Year) 1 □ M 2 🛣 F Days Hours Months Min 212-32-0372 76 Director March 22,1934 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov other traumatic event, the Medical Examiner must be notified at Yes 2□No Director Harford Maryland Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 107 Weber St. 21078 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural", or iter 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No þ Specify. Specify: White 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civil Service Computer Operator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Hambleton Celia McCasland 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maureena Tiffany / Daughter 200 Garner Dr, Aberdeen, MD 21001 Baltimore, permit. Pages 1 a
Department of Her
Important: If item
any Injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State W.Nottingham Cemetery 7/30/2010 Colora 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
333 S. Parke St., Aberdeen, MD 21001 21. Signature of Ju Service Live rances 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each [1] Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 

Ectopic pregnancy in the past 12 months? Month Year Day signed by the a 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? à 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 No 1 ☐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Maneer of Peath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☑ No 2 Accident 24 hours after deatle Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of c 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature 31. Date filed (Month, Day, Year) State 29 Registrar

DHMH 17 Rev 1/2001

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Mordechai Vers	schle	eisser 1- For State Registrar	State of Mary		artment o ertificate o		l Mental I	, ,	201	0 23665
Physic Medical Exam		1. Decedent's Name (First, I		SCHLEIS	SER			2. Date of Dea Month July 27, 2	th Day Year	3. Time of Death 0640 hrs
		4a. Facility Name (if not inst Sinai Hospital	titution, give street and r	number)		4b. City, Town, or L Baltimore	ocation of Dea	th	4c. County of	Death N/A
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs.	-	If Under 1 Year Months Days	If Under 24H	n	th(MM/DD/YYYY)	9. Birthplace (State or oreign
		NONE Usual Residence of Decede		1	Yr	5 2 22		05/05/	2010	Country) I SRAEL
and show an	 	10a. State 10b. Cou	N/A	10c. City	y, Town or Loca	BALTIMORE				10d. Inside City Limits 1 XX Yes 2 No
he Maryl 1 or 28a-1 ified at 9	Director	10e. Street and Number 6204 WIRT AV	/FNUF			10f. Zip Code 212	15	1	Og. Citizen of What	
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If the 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 XXX Never Married 2	12. Was De	cedent Ever in U Forces? 2XX No		as Decedent of Hisp es, specify Cuban,	anic Origin? ( S		14. Race - A White, e	American Indian, Black, etc.
iours after natural", (xaminer	ed by	3 Widowed 4  15. Decedent's Education (	Divorced of Dates: (Specify only highest gra		16a. Deceder	Yes 2 X No nt's Usual Occupation nost of working life. D	on (Give kind of	work done	Specify: 16b. Kind of Busin	WHITE ess/Industry
1036 rithin 72 h ene. er than "r Medical E	ompleted	Elementary/Secondary (0-	-12) College (	1-4 or 5+)	- during it	NONE	DO NOT use re	irea)	NON	E
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Menhal Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	Be Co	17. Father's Name (First, Mid CHAIM	VERSCHLI	EISSER			NILI	e (First, Middle, M	FINE	
MD 2 td 2 should tlth and M m 27 is m	To	19a. Informant's Name/Relat			6204	g Address (Street a	NUE, BA	LTIMORE,	MD 2121	5_
Baltimore, permit. Pages 1 ar Department of Hee Important: If itee		20a. Method of Disposition  1 XX Burial 2 Crema  4 Donation 5 Othe		rom State	crematory or ot	ition (Name of ceme ner place) JCHOS CEM		Date 28 / 20 10	20c. Location - Ci JERUSALEI	
Baltii permit. Departm Importa		21. Ignature of Funeral Sen		1177	22. N	lame and Address o	of Facility SOL	LEVINSO	N & BROS	, INC. , MD 21208
Physician /Medical		23a. Part I. Enter the disease failure. List only one ca	iuse on each line.		n. Do not enter ti	ne mode of dying, su	uch as cardiac o	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
'Examiner		Immediate Cause (Final dise or condition resulting in deat		a consequence of		icy				
	Examiner	Sequentially list conditions, if any, leading to immediate course. Enter Underlying Co. (Disease or injury that initiate	(190)	a consequence o	of):					-1
50, te be executed sysician and bunial - transit	al Exa	events resulting in death) La		a consequence o	of): 					
<b>60,</b> Ite be ex hysician e burial	Medical	UNPENDED  IF FEMALE:	AMENDED 23c If yes	outcome of preg	mancy				22d Data of dal	
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	siciar	23b. Was decedent pregnant past 12 months?	in the 1 Live t	oirth nant at time of de	2 Fe	tal death 3 ner (Specify)	Ectopic pregna	ancy	23d. Date of del Month	very Day <b>Y</b> ear
P.O. E	by Phys	Part II. Other significant cor			esulting in the u	nderlying cause give	en in Part I.			e to the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed			-				24a. Was a autops	n 24b. Were	autopsy findings available to completion of cause of
tal Rec		25. Was case referred to med	dical			26.Place of	Death (Check	perform 1 Yes 2 only one)		Yes 2 No
n of Vitz ding Physici. After this co	To Be	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 🗸	of Injury	ER/Outpatient			<del></del>	Residence 6 0	ther:
ision ( Attending r death. ector: Af ethe fun	Certification:	2 Accident Ir	Pending FOUND Jul 21, 2	Day,Year) 2010	FOUND: 1908 hrs		s 2 🗸 No	Unknown		
Divis To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Certifi	4 Homicide	etermined (Specify)	Single Fan	nily			or Town, Sta 6307 Red Ceda	ate) ar Place, Baltimo	
To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only one) 2 Medical E	Physician: To the bes Examiner: On the basis of and manner s	of examination a	ge, death occurr nd/or investigati	on, in my opinion, de	eath occurred a	due to the cause t the time, date a	(s) and manner as and place, and due to	stated. o the cause(s)
	Σ	29b. Signature and title of cer	Q M	NE		29c. License n			29d. Date signed ( July 27, 2010	Month, Day, Year)
5v	İ	30. Name and address of personal Jack Titus MD.	son who completed caus Deputy Chief Medic			n Street, Baltim	nore, MD 21	201		
St Regist	ate	31. Date filed (Nogh 2010	ar) Deneu 32. Re	gister's Sign	a Kel					.,

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				<b>pe or Print i</b> State of Maryla				-				
		_	State Registrar		Cer	tificate of	Death		Reg. No	2010	23666	i
Physi	ician		1. Decedent's Name (First, Middle, Last)  Gary Was	hington				2. Date of De Month	eath	y Jol	3. Time of Death 3:30PM	
, Exar			4a. Facility Name (if pot institution, give stree				r Location of Dea	th /		. County of Dea	th	_
			Bon Secours A 5. Social Security Number 6. Sex	tospital	rs. last birthday)	If Under 1 Year	altimor				N/A	
Funer Direct	or		220-68-1517 Usual Residence of Decedent	2 □ F	42 Yrs.	Months Days	If Under 24 Hrs Hours Min		23, 196	9. Bi	rthplace (State or Foreign ountry) <b>Maryland</b>	_
aryland ta-f shov ified at		ector	10a. State 10b. County  Maryland N/A	10c.	City, Town or Loc		Baltimore				10d. Inside City Limits 1 ☐ Yes 2 ☐ No	_
/ith the M 23a or 28 st be not		Funeral Director	10e. Street and Number  601 Wynoke Avenue			10f. Zip Code	21218	- 6	10g. Cit	izen of What C		ì
eath v tems	١.	i r	11. Marital Status 12. \	Was Decedent Ever in		Vas Decedent of H	lispanic Origin? (S	Specify Yes or No-	- 1	14. Race - Ame		_
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		ຊ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐xNo If Yes, Give Year or Dates.		Yes, specify Cuba	an, Mexican, Puer Specify:	to Rićan, etc.)		Black, Whit		
15-C 72 hou "natu ledical		Completed	15. Decedent's Educati (Specify only highest grade co		(Give k	ent's Usual Occup	during most of wo	rking	16b. K	ind of Business	Industry	_
212 within giene.		5	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DC	NOT use retired)	isabled	-		Dis	sabled	
land be filed ental Hyg rked oth ic event,	1	10 Be	17. Father's Name (First, Middle, Last)  Samuel Ro	binson	_		18. Mother's Na	me (First, Middle,		Surname) <b>/. Humbert</b>		
Baltimore, Maryland 21215-0036 Department of Health and Mental High within 72 hours after Department of Health and Mental Highene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exami			19a. Informant's Name/Relationship (Type, P	rint)			and Number or Ru Road Colun				p Code)	_
or Hear fitem		ŀ	20a. Method of Disposition		o. Place of Dispos		- <u> </u>	Date		ocation - City or	Town, State	-
time trent trant: Itant			1 Burial 2 Cremation 3 Remo	oval from State	-	o Crematory		07/29/10	1.	Catonsvill	e, Maryland	
Bal permi Depar Impo	ouce		21. Signature of Fundal Service Licensee	Ostest	7	1300 F	Brothers Fur	Raltimore N	Vid 212	17		
			23a. Part 1 Enter the disease, or complication shock, or heart failure. List only one cau	use on each line		the mode of dyin	g, such as cardiad	or respiratory ar	rrest,	£	Approximate Interval Between	
→ Physicial		1	Immediate Cause (Final disease or condition resulting in death)	Due to Us a conse	ensive 1	Therosul	exotic Ca	tdiovasu	Mar	JECASE	Onset and Death	3
Examin	•	.	Sequentially list conditions, b. —	10.42	54401.00 01/1							
uted d ansit	Lyaminor		if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c. —	Due to (or as a conse	equence of):							
be executed sician and burial-transit			resulting in death) Last	Due to (or as a conse	equence of):							_
	Apolic		d			_						_
P.O. Box 68760 that the death certificate be exceed by the attending physician edetached for use as the burial	Dhysician/Modiy	y siciality	in the past 12 months?	f yes, outcome of preg Live Birth 2 F. Pregnant at time of Unknown	etal death 3 🗌	Ectopic pregnand Other (specify)	;y			23d. Date of de Month	livery Day Year	
	٤	בר   בר	Part II. Other significant conditions contribu	iting to death but not r	resulting in the un	derlying cause giv	en in Part I.				the cause of death?	_
ords requir been s	Poto		Diagnes								robably 4 Unknown	_
Hec The law ate has page 2	Completed		Morbid Obesin	1				24a. Was autor perfo	osy ormed?_	prior to death?	topsy findings available completion of cause of	
/Ital sician certifi irector	88	14	25. Was case referred to medical examiner?  1 ✓ Yes 2 ☐ No  Hospit	al:		Othe	ace of Death (Che		_			
Of V g Phy: er this	- F		27. Manner of Death 28	1 ☐ Inpatient 2 [ Ba. Date of injury (Month, Day, Year)	28b. Time of	28c. Injury	4	lome 5 Resid			ify)	-
SION Attendin death. ctor: Aft y the fur	Certificate.		1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	Be. Place of Injury - At	injury		? Yes 2 \( \text{No} \)	29f Leastine /	Dannak a mar	I & to see Land and Thomas	Devike Misselve	_
DIVI pital or / burs after eral Dire			4 Homode determined	building, etc. (Spec	sify)			City or Tow	n, State)		al Route Number,	
DIVISION Of VITAL To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical		29a. Certifier 1 Certifying Physician: (Check 2 Medical Examiner: Only one) 3 Certifying Nurse Practice.	n the basis of examinat	ion and/or investig	gation, in my opinio	n, death occurred	at the time, date a	nd place,	and due to the	ause(s) and manner stated	
<b>5</b> wit o o			19b. Signature and title of certifier  Mar and Cortifier  10. Name and address of person who comple  Mar as Cortifier  Mar as Cortifier  1. Date filed (Month, Day, Year)	D		29c, License	56240		29d. Date	signed (Month	, Day, Year)	
3		3	0. Name and address of person who comple	ted cause of death (Ite	em 23a) (Type, Pri	nt)	•	L	7	7 = 0 ]	-010	+
	tate	3	Marua Cort, mo B  1. Date filed (Month, Day, Year)	32. Registrar's Side	Hospital &	2000.W.	Bactomo	e Street	Be	iltimore	MD 21223	
	trar		MH 292010 Proces	1 10. 4	Aires							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ronald Withey Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death -25/01 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign New Tork **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min. No Mon 1 Day, 1938 095-32-9159 71 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits Dorchester Hurlock 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 45 Delaware Avenue #10 21643 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Completed by 1 Never Married 2 Married white If Yes, Give Year or Dates 1 Tes 2 No Specify: Specify: 3 Widowed 4X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unit Baltimore, Maryland 21215 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) unk College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Lewis Withey Velda Vantassell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Memorial Hospital 219 S. Washington St; Easton, Maryland 21601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 D Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Sign ture of Funeral Service Lic 655 W. Baltimore St; Baltimore, Maryland 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician/ termou Medical resulting in death Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DQA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending ☐ Accident ☐ Suicide Investigation

Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 112010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2160

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g906 8-16-10 vt. State of Maryland / Department of Health and Mental Hygiene State
Registra 23668 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 07 2010 1:25 A M RONALD F. WILLIAMS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL HOSPICE OF CHESAPEAKE HARWOOD 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** <u> 70-8308</u> 1**X**□ M 2 □ F Months Days Hours Min Director 05/30/1945 VIRGINIA Usual Residence of Decedent ems 23a or 28a-f show must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director PRINCE GEORGES UPPER MARLBORO Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 10 STATON DRIVE 20774 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2X No other traumatic event, the Medical Examiner Black, White, etc. ρ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates Specify: BLACK 1 ☐ Yes 2XXNo Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SELF-EMPLOYED TRUCKING COMPANY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic evenore. and Mental H ၉ LOUISE HANKINS HENRY K. WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 STATON DR., UPPER MARLBORO, MD 20774 VIRGINIA ANN WILLIAMS/WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) FT. LINCOLN 08/02/2010 BRENTWOOD, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARSHALL'S FUNERAL HOME 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Metastatic cancer of liver & lungs disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Colon Cancer 4 years Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Diabetes mellitus Completed 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? cate has by page 2 s performed? Yes 2 No. 2 🗌 No Yes 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Hospice house
6 N Other (Specify) 1 Tes 2 No Other: 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury work 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director,
completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifie 29c. License number D0014905 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Year-Kwon H. Yoon, M. D. 7307 Baltimore Ave. Ste #111 College Park, MD 20740 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

			1 - For State Registrar	State of	Marylar		artmen <i>tificate</i>			and M	1ental Hy	•	2011	1	23669
	Physicia	an/	Decedent's Name (First, Middle, Land)	ast)	,		imoun	0, 0	Catri		2. Date of De				3. Time of Death
_	Medi Exami	cal	4a. Facility Name (if not institution, giv	th W	hear	DN	4 0		Location o		July	33	,	0	9:17PM
	Exami	iei	2913 Liberty		,		'	idal		T Death	•		County of D		9
	Funeral Director		219-12-4817	Sex 1  M 2	Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrş. Min.	8. Date of Bir 1 2 - 31	th ay, Year)	25	Birthpl Countr	ace (State or Foreign y) MD
	and show at	5	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Loc	ation							10	d. Inside City Limits
	Maryla 28a-f otified	irect	MD Baltin	nore	Du	ındalk									1 ₺ Yes 2 □ No
	with the s 23a or ust be n	Funeral Director	10e. Street and Number 2913 Liberty E	lace			10f. Zip	Code 222				10g. Cit	izen of What	Count	y?
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces 1  Yes 2 If Yes, Give Year or Dates	No No	1f	Vas Deced Yes, spec	ify Cuban	, Mexican,	in? (Spe	cify Yes or No- Rican, etc.)		14. Race - A Black, W Specify: Wh	hite, et	c.
Baltimore, Maryland 21215-0036	within 72 hou giene. <b>ier than "natu</b> t <b>, the Me</b> dical	Completed	15. Decedent's (Specify only highest g Elementary/Seconday (0-12)	Education rade completed) College (1-4 c	r 5+)	life. DC	ent's Usua ind of wor NOT use Cler	k done du retired)	tion uring most	of workir	ng	16b. Ki	ind of Busine	ss Indu	stry
land ;	be filed v lental Hyg rked othe ic event,	To Be	17. Father's Name (First, Middle, Last) Walter Prestor				CICI				(First, Middle,			· <u>y</u>	. 0003
lary	should be file and Mental   7 is marked of raumatic eve		19a. Informant's Name/Relationship (	Type, Print)		19b. Mailin	g Address	(Street an			Route Numbe	r, City or	Town, State,	Zip Co	de)
e, r	and 2 and 2 the Health tem 27 other tr		Paula Sexton -  20a. Method of Disposition	Daught		202		_	o Av		Dunda				
mor	Page 1 nent of ant: If it		1 Burial 2 XCremation 3 4 Donation 5 Other (Spec		te c	emetery, crem	atory or ot	her place,			-2010		timor		
Balt	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Licen	see		22.	Name and	d Address	of Facility	Bra	adley- Spring	Ash	ton F	une 122	eral Home
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caus	ed the death								<u>au, 2</u>	/	Approximate
;=:I	Physician/ Medical	i i	Immediate Cause (Final disease or condition resulting in death)	u.	Y O CA	Roles	In!	FAR	ctron	)					Onset and Death
	Examiner	_	Sequentially list conditions	b — Due to (or a	s a consequ	ience oi):									
	ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or a	s a consequ	ence of):								3	
	icate be executed physician and s the burial-transit	al Exa	that initiated events resulting in death) Last	Due to (or a	s a consequ	ence of):								+	
200	cate be physic s the bu	edical		d				_						+	
. Box 687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1  Live Birth 4  Pregnant 9  Unknowr	2 Fetal	Ideath 3	Ectopic pr Other (spe	regnancy ecify)					23d. Date of o		ay Year
P.0	s that the gned by se detac	by Pr	Part II. Other significant conditions of			ulting in the un	derlying ca	use giver	n in Part I.		23e. Did to	bacco us	se contribute	to the	cause of death?
rds,	equires	eted	Ischemic	Colifi	5					-	1 🗆 \	/es 2 [	₹No 3 🗆	Proba	oly 4 🗆 Unknown
Division of Vital Records, P.O.	The law acate has be page 2 s	Completed	Hyperteus	LON							24a. Was a autop perfor	sy med? ,	24b. Were a prior to death? 1 🔲 Y	o com	findings available pletion of cause of
/ital	sician: certific lirector,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:				Othor	e of Death		only one)				
of o	ng Phy fter this ineral d	ite: T	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	1 ☐ Inpa 28a. Date of in (Month, D	ury	ER/Outpatient 28b. Time of injury		c. Injury a	4 L Nurs		ne 5 Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residada Residad			ecify)	
Sion	Attendii death. ctor: A y the fu	ertificate;	2 Accident Investigation 3 Suicide 6 Could not be	1			M M	1 🗆 Ye	s 2 🗆 N	-					
Ω̈́	tal or A Irs after al Dire	0	4 L Homicide determined	building, e	tc. (Specify)	ne, iann, stree	n, ractory,	unice		2	8f. Location (St City or Town	treet and n, State)	Number or F	Rural Ro	oute Number,
	To the Hospital or Attending Physician: The law within 24 Juous after death.  To the Funeral Director. After this certificate has a completed filled in by the funeral director, page 2 s.	Medical	29a. Certifier 1 Certifying Phy (Check 2 Medical Examonly one) 3 Certifying Nur.	ner: Un the basis of	examination.	and/or investig	ation in m	v oninion	doath occu	irrod at th	no timo data ar	d place	and due to the	001100	(s) and manner stated.
	Nith Co.		29b. Signature and title of certifier			MP	29c. I	License n	umber		2	29d. Date	signed (Mon	ith, Daj	, Year)
	η,	ŀ	30. Name and address of person who	completed cause of	death (Item :			000	7740			July	70	( 4	2010
	d V			RD Ste.	102	Tows		MO	21	286	3				
	State Registra	~	JUL 292	010 Sen	rar's Signatu	B. 4	ark	P							

10-05489 Gage Williams

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Certificate of Death Certificate of Death

		Registrar	-	C	ertificate d	or Death	_	<u> </u>	Reg. No.		
Physic			die,Last)					Date of D     Month		Year	3. Time of Death
Medical Exam	ше		···					July 22,			2348 hrs
		4a. Facility Name (if not instituti		umber)		4b. City, Town,		Death		ity of Death	
		N/B Williams Beans i				Upper Ma			Prince	George	e's
Funera		5. Social Security Number	6. Sex		s. (ast birthday)	If Under 1 Y	ear If Under ays Hours		Birth(MM/DD/YY		thplace (State or
Director	1	578-19-9025	1XM 2F	19	Y		ays Hours	Min. Aug.	4,1990	Co	Wash. D.C.
*		Usual Residence of Decedent						<u> </u>			
A BU	ı	10a. State 10b. County		10c. Ci	ty, Town or Loca	ation					10d. Inside City Limits
daryland 28a-f show any 1 at once,	5	MD PG		Up	per Mar	lboro					1 X Yes 2 No
Mary 28a- d at s	Director	10e. Street and Number		-		10f. Zip Code			10g. Citizen of	What Cour	ntry?
the ]	ä	4813 Parkmont	Ln			20772			U.S.A.		
r death with the Maryland or items 23a or 28a-f sho must be notified at once,	Funeral	11. Marital Status		cedent Ever in		as Decedent of I	lispanic Origin	n? ( Specify Yes or I	No- 14. Ra	ace - Ameri	can Indian, Black,
death or ite	Š	1 X Never Married 2 N	Armed F	2 X No	"	Yes, specify Cub	an, Mexican, F	Puerto Rican, etc.)	l w	hite, etc.	
after al", o	J A	3 VVIdowed 4 DI	vorced If Yes, Give Yes	ar	1	Yes 2X	No specify:		Specif	Black	
215-0036 be filed within 72 hours after and Hygene. ked other than "natural", the Medical Examiner.	g	15. Decedent's Education (Spe	ecify only highest gra	de completed)	16a. Decede	nt's Usual Occup nost of working li	oation (Give kir	nd of work done	16b. Kind of	Business/li	ndustry
6 172 } an "r cal E	Completed	Elementary/Secondary (0-12)	College (	1-4 or 5+)				se retired)			
003 within er th Medi	Ĕ	12th			Custom	er Servi	.ce		Starbu	cks	
5-C			•				18.Mother's	Name (First, Middle	, Maiden Surnar	me)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	BB	Robert William	-				Joyce	Allen			
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 15 market other than "matural?, or items 23a or 28a-f she ratic event, the Medical Examiner must be notified at once	ြို	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	g Address (Str	eet and Numbe	er or Rural Route N	umber, City or To	own, State,	Zip Code)
Z purgalth 2		Robert William	s/Father		3909	70th Ave	Lando	ver Hills			
Baltimore, Nermit. Pages I and Department of Healtl Important: If item injury or other trau		20a. Method of Disposition  1 Burial 2 X Cremation	n 3 Removal fr		<ul> <li>Place of Dispo crematory or o</li> </ul>	sition (Name of o ther place)	emetery,	Date	20c. Locatio	n - City or	Town, State
Baltimore permit. Pages   Department of F Important: If i		4 Donation 5 Other S			verdale	Pk Crem	ntory 7	-28-2010	Riverd	ale,M	ID
alt mit. spartr sport iport		2 gnature of Funeral Service	Licensee	0	22.	Name and Addre	ss of FacilityR	onald Tay	lor II	Funer	al HM.
<b>m</b> 88 E E		herobo //	15 NOV	all/	110	8 W. Nor	th Ave	. Baltimo	re.MD 2	1201	•
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that c	aused the deal	h. Do not enter	the mode of dying	g, such as card	diac or respiratory a	rrest, shock, or I	neart	Approximate Interval
/Medical Examiner		Immediate Cause (Final disease	Ad Mint DI	unt Force Ir	juries						Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a	consequence	of):						
	<u>.</u>	Sequentially list conditions,	b								
	ine.	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence	of):						
4	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence	of):					-	
cuted md transi			d								
18760, rificate be executed ng physician and as the burial - transit	Physician/Medical	UNPENDED	AMENDED					-			
38760, rtificate be fing physici as the buri	Me	IF FEMALE:	23c. If yes, o	outcome of pre	gnancy				23d. Date	of delivery	
o i i g s l	ian	23b. Was decedent pregnant in the past 12 months?	I I Live b		_ =	etal death 3	Ectopic pr	regnancy	Month	Da	ay Year
Box 6 e death cerr the attendii ed for use a	sic	1 Yes 2 No 9 Unk	known 9 Unkno	ant at time of d	eath 5 O	her (Specify)			4		7
rds, P.O. Box 6 requires that the death cer been signed by the attendi hould be detached for use	Phy	Part II. Other significant conditi			resulting in the	Inderlying cause	given in Bert I	230 Did	obass use san	dribuda da di	he cause of death?
P.O. es that the igned by	þ		on the contributing to	death but not	resulting in the t	inderlying cause	giveniniranı				ably 4 Unknown
quire quire and be	ted			<del></del> .				_			· —
Records,  The law require ficate has been si, page 2 should b	Completed		<del> </del>					24a. Was	psy	prior to co	opsy findings available empletion of cause of
Rec The I	ĕ								ormed?	death? 1 ✓ Yes	2 No
tal Recian: The certificate	Ф	25. Was case referred to medical examiner?				26.Plac	e of Death (Ch	neck only one)		-	
Division of Vital lat or Attending Physician: rs after death.  al Director: After this certiied in by the funeral director.	To B	1 ✓ Yes 2 No	Hospital: 1 1	npatient 2	ER/Outpatient	3 DOA	Other ₄ N	lursing Home 5	Residence 6	✓ Other:	Scene
1 of Jing Ph After t	핕	27. Manner of Death	28a. Date (Month.	of Injury Day, Year)	28b. Time of I	.	ury at Work?	IDaaaaaaaa	how injury occu		
ion tendi	읥	1 Natural 5 Pend 2 Accident Inves	ing Jul`22, 2	010	0000 hrs	1	Yes 2 🗸 No	Passenger	auto fixed o	bject col	lision
ViS or At fiter d Direct in by	ı≝			of Injury - At h	nome, farm, stree	et, factory, office	building, etc.			ber or Rura	al Route Number, City
Div pital or ours afte eral Dir filled in	Certification:			Major Roa	d / Highway			or Town, S N/B Williams	State) Bean Road, L	Jpper Mar	rlboro, Md.
		29a. Certifier 1 Certifying Ph	ysician: To the best	of my knowled	lge, death occur	red at the time, d	late and place,	, and due to the cau	se(s) and manne	er as stated	1
To the How within 24 h To the Fur completely	Medical	one) 2 Medical Exar	niner: On the basis o and manner st	f examination a	and/or investigat	ion, in myopinio	n, death occur	red at the time, date	and place, and	due to the	cause(s)
FSFS	ž	29b. Signature and title of certifier				29c. Licens	se number		29d. Date sign	ned (Monti	h, Day, Year)
		11111			17	O.C.	M.E.		July 23, 20	010	
1.	ŀ	30. Name and address of person	who completed cause	e of death (Iten	n 23a)					-	
$\propto V$		Russell Alexander MD		,	,	Penn Street	Baltimore	, MD 21201			İ
St	ate	31. Datgipp (M2 9 2010)	Cleve 32 Reg								
		ABUIL MUZUIU	~~~	1- 17				OCA	AF		

Pertient Known as William Irvin Weinstein Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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		State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg. N2									010	)	236	71		
		Decedent's Name	e (First, Middle, L	_ast)							ath	010	, T	3. Time of		
Physicia Medio		WILLIAM	1		WE]	INSTEIN			_Month	By 6	Yea	010	1742			
Examin		4a. Facility Name (if	not institution, g	ive street and number	1)time	4b. City, Town, or Location of Death Raltimore City						4c. County of Death N/A				
Funeral Director		5. Social Security No. 220-20-3	umber 6		Age (In yrs. I	ast birthda Yrs.	Monthe Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Birt			Birthpla Co <i>untry</i>	ce (State o	r Foreign	
land f show d at	tor	Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	10c. City, Town or Location									ty Limits	
e Mary r 28a- notifie	Direc	MD 10e. Street and Num	N/A		BA	BALTIMORE						40 - CW				
death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral Director			TS AVENUE	. #302	#302 10f. Zip Code 21215					10g. Citizen of What C					
leath Items Ier mi	Fun	11. Marital Status	nt Ever in U.S		3. Was Decedent of Hi	ispanic Or	rigin? (Spec	ify Yes or No-	14	Race - Ar	nerican					
permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner musonce.	ted by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces?  1 ☑ Yes, Give Year or Dates.				If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2  No Specify:						Black, White, etc. Specify: WHITE				
72 hou n "nat fedica	Completed	15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working						16b. Kind of Business Industry				
within giene. er tha	Cor	Elementary/Seco	onday (0-12)	College (1-4 o 5+	or 5+)	1	DO NOT use retired) CORNEY				AT	LAW				
filed rital Hyged ed oth	To Be	17. Father's Name (F	First, Middle, Las							First, Middle,	Maiden Sur	· ·				
ould be d Men marke matic	-	NATHAN 19a. Informant's Na	ma/Bolotianshin		NSTEIN	T			TRUDE			LAZA				
d 2 shc alth an 27 is ir trau		LORAINE				11	ailing Address (Street a				-				21215	
of Hex of Hex if item r othe		20a. Method of Disp	oosition	Removal from Sta		lace of Dis	position (Name of rematory or other place	1		nte I		tion - City				
t. Page tment tant: I jury o	9	4 Donation	5 Other (Spe	ecify)	210	H EL	MEMORIAL :	PK.	7/28/			ALLSI				
permit Depar Impor any in	,	21. Signe ure of Fur	LALL II	gsee 11141			22. Name and Address 8900 REIS'								208	
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ith cert	ian/I	23b. Was decedent		23c. If yes, outcom	h 2 🗌 Feta	death 3	Ectopic pregnanc	У			230	d. Date of o	delivery D:		'ear	
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es that t signed b be deta	by P	Part II. Other signifi	_		h but not res	ulting in the	e underlying cause giv	en in Part	1.		bacco use					
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The law ate has bage 2	Completed by	autopsy pri performed? de										o comp	letion of ca			
Physician: The laver this certificate has ral director, page 2	Be	25. Was case referre examiner?	ed to medical	Hospital:		-34			ath (Check o		2 (3) (40)		72.			
Physic this c	.: To	1 ☐ Yes 2 ✓ 27. Manner of Death	No No	1 Vinp		ER/Outpat	ient 3 DOA Other	4 ∐ N		e 5 Resid			ecify)			
nding ath. r: After	icate	1 M Natural 2 Accident	5 Pending Investigat	(Month, I	Day, Year)	injury	work		_	d. Describe in	ow injury oc	curred				
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but	Certificate:	3 ∐ Suicide 4 ☐ Homicide	6 Could no determine	28e. Place of I	njury - At ho etc. (Specify		street, factory, office		28	3f. Location (S City or Tow		umber or F	Rural Ro	oute Numb	9 <i>r</i> ,	
Hospita 24 hours Funeral sted filler	Medical	(Check 2	Medical Exa	miner: On the basis o	f examination	n and/or inv	h occured at the time, estigation, in my opinio	n, death o	ccurred at the	ne time, date a	nd place, an	d due to th	e cause	s(s) and mar	nner stated.	
To the within To the Comple		only one) 3 29b. Signature and t		urse Practioner: To t	he best of my	knowledge	e, death occurred at the 29c. License		e and place,		29d. Date s	igned (Moi	nth, Da	y, Year)		
		• / \	dr (		an		RES	. 0	00		Iv	iy	26	, 20	210	
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Stat Registra		31. Date filed (Month	n, Day, Year)	Ceneral 32, Rogh	strar's Signat	back		-								
MH 17 Rev 7/20		700	THE STATE OF	1-4-1-	1- 17											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 7:15 AM 2010 **JESSE** WINSTON a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17 and Rehabilitation 150 Garden MORE a War If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/11/1912 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days Hours 1**X** M 2□ F 98 057-01-9458 **ENGLAND** Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ural", or Items 23a or I Examiner must be 16 OLD COURT ROAD, #202 21208 USA Funeral . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE Completed by 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 SALES MANAGER WHOLESALE SHOES Department of Health and Mental Hygis Important: If item 27 is marked other i any injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be be Pages 1 and 2 should I nent of Health and Men WINSTON 2 CELIA ELLISON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) KAREN LEVIN/DAUGHTER 2151 MOUNT VIEW ROAD, MARRIOTTSVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH EL MEMORIAL PK. 07/28/2010 RANDALLSTOWN, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Meart **Physician** DING /Medical Due to (or ** a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 🔲 Yes 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one 1 Tes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Leath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Injury at 6 Work? 1 Natural 5 Pending investigation Injury 1 Yes 2 No death. 2 Accident To the Hospital or Attenwithin 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Na 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

ax



Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scutts

29c. License number

29d. Date signed (Month, Day, Year)

2010

			4 X.	epartment of Health and Mer	ntal Hygier	1e 2010 22672
			Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. I	
	Physicia Medic		MOLLY N WILLEN		Date of Death Month JULY 25	
	Examin	ier	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	Funeral		GILCHRIST HOSPICE CARE  5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)		Date of Birth	BALTIMORE  9. Birthplace (State or Foreign
	Director	ı	214-14-9978 1 DM 2XXF 90 Yrs	Months Days Hours Min.	(Month, Day, Year 2/03/192	O Country) RUSSIA
	or Jow	١	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location		10d. Inside City Limits
	anylar ta-f sl	ecto	MD N/A BALTI			1 1 Yes 2 □ No
	or 28 e not	قَ	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	s 23a uust b	Funeral Director	3031 FALLSTAFF ROAD, #106C	21209		USA
	death item ner m	F	Armed Forces?	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rical)	Yes or No- in, etc.)	14. Race - American Indian, Black, White, etc.
36	e filed within 72 hours after death with the Manyland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XXX No If Yes, Give Year or Dates.	1 ☐ Yes 2 🗶 No Specify:	, ,	Specify: WHITE
9	hours latura ical E	ete	15. Decedent's Education 16a. De	cedent's Usual Occupation	166	Kind of Business Industry
215	in 72 e. nan "r	duc	(Specify only highest grade completed) (GElementary/Seconday (0-12) College (1-4 or 5+)	ive kind of work done during most of working b. DO NOT use retired)		
21	d within ygiene. her tha it, the I	Be Co	12	TECHNICIAN	D	ENTISTRY
Maryland 21215-0036	ild be filed v Mental Hyg narked othe	70 B	17. Father's Name (First, Middle, Last) LOUIS OWRUTSKY	18. Mother's Name (Fire	rst, Middle, Maide	·
Ž	1 and 2 should be fi f Health and Mental item 27 is marked other traumatic ev	ľ		ROSE ailing Address (Street and Number or Rural Ro	uto Mumbou City	GRUBER
Ž	d 2 sh alth ar 27 is ir trau	9		BRYNMOR COURT, #504,		
ore,			20a. Method of Disposition 20b. Place of Di	sposition (Name of Date termatory or other place)		Location - City or Town, State
<u>E</u>	Page ment o tant: If ury or	- 51		ONTEFIORE CEM. 7/26/2	2010 B	ALTIMORE, MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Liberge	22. Name and Address of Facility SOL	LEVINSO	N & BROS., INC.
_	44 = 10 0		23a. Part 1. Enter the disease, or complications that caused the death. Do not	8900 REISTERSTOWN ROA		
	Physician/	e 15	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	MUM Sucreas Cardiac of res	spiratory arrest,	Approximate Interval Between Onset an Death
	Medical Examiner		resulting in death)  a.  Due to (or as a consequence of):			74.474.70
	it d	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying			
	ate be executed ohysician and the burial-transit	Exar	Cause (Disease or iinjury that initiated events c. Due to (or as a consequence of):			
09	r be ey rsician buria	dical	d			
376	fficate ig phy as the	Medi	IF FEMALE:			
Box 687	eath certifica attending pl	an/I	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	3 Ectopic pregnancy		23d. Date of delivery
Bo	re deat the at thed fo	Physician/Me		5 Other (specify)		Month Day Year
P.O.	v requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
ds,	quires en sign uld be	Completed by			1 🗆 Yes	2 No 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records,	has be	uple			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Be	The cate h	Con			performed?	
ta	certifi	m	25. Was case referred to medical examiner?	26. Place of Death (Check only	/ one)	10000
	Phys r this aral dii	<u>و:</u>	1	tient 3 □ DOA 4 □ Nursing Home	5 Residence Describe how inju	
ouc	inding ath. r: Afte ie fune	icat	1 № Natural 5 ☐ Pending (Month, Day, Year) injur	work?  M 1 □ Yes 2 □ No	Doddingo now maj	ary coodinod
/isi	r Atte ter de recto	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		Location (Street a City or Town, Stat	and Number or Rural Route Number,
ا ک	ortal o urs afi ral Di		1			
:	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one)    Certifying Physician: To the best of my knowledge, deal control on the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination and the basis of examination	restigation, in my opinion, death occurred at the ti	time, date and place	ce, and due to the cause(s) and manner stated
	Vith Com		29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)
	92		20 Name and address of payees who completed a very of death (hours 60 ) 77	Print)	7	70450N ND
	5V		30. Name and address of person who completed cause of death (Item 23a) (Type AACO) J (AACO)	3701 N. Charle	s ST	TOUSON MO
	Stat Registra	_	31. Date filed (Month, Day, Year)  JUL 29 2010  August 232. Registrary Signature	1		

			State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg. N2 0 1 0 2 3 6 7 4										
			Registrar  1. Decedent's Name (First, Middle, Last)		Reg. N2 0 0 2367								
	Physicia		William M. W	n Sr			2. Date of Dea	Day 2 4	Year	3. Time of Death 2/12/6 M			
	Medio Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or	Location of	f Death	*4,7		y of Death				
No.			Seasons Hospice of Baltimore				Randa	llstown			imore		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bi	- ,	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min,	8. Date of Birti		9. Birth	place (State or Foreign		
	Director		242-46-3641 74 Usual Residence of Decedent	Yrs.		1100.0			2, 1936		o Carolina		
	nd thow	=	10a. State 10b. County 10c. City, Tov	wn or Lo	cation					1	Od. Inside City Limits		
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director	Maryland N/A		В	Baltimore	Э				1 ☐XYes 2 ☐ No		
	the N	٥	10e. Street and Number		10f. Zip Code				10g. Citizen of	What Cour	ntry?		
	s 23s	era	6235 Pioneer Drive			212	214			U.S	.A.		
	death item ner n	Ξ	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. \	Vas Decedent of His f Yes, specify Cubar	spanic Orig n, Mexican,	in? (Spec Puerto F	cify Yes or No- Rican, etc.)		ce - Americ			
36	after al", or xami	d by	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No If Yes, Give 1954	1   1	☐ Yes 2 ☐ XNo				Specify		Black		
Ö	nours latura ical E	Completed	15. Decedent's Education 16.		lent's Usual Occupa	ntion	_	- 1	16b. Kind of E	lucinace In			
215	n 72 h an "n Medi	d L	(Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5+)										
2	withi giene er th		12		Postal S	Postal Service Police					U. S. Government		
nd	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last)		:	18. Mother	r's Name	(First, Middle, I					
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	-	Foster Anderson						Villie Jone				
Ma	2 sho th and 27 is r traur				g Address (Street a					State, Zip (	Code)		
ē,	and Heal tem 2		Brenda Wilson  20a. Method of Disposition  20b. Place		235 Pioneer I	Dilve Ba		e, Marylan	20c. Location	- City or To	own State		
ΠO	Page 1 nent of ant: If it ury or o		1 Deurial 2 Cremation 3 Removal from State cemet	ery, cren	natory or other place	1		07/29/10		•	Mills, Md.		
ij	permit, F Departm Importar any injur		21. Sign, ur of Furniral Service Licensee		orest Veteran:  Name and Address			01720119		wingo	rino, ivia.		
Ö		3	Ceul 4 Stera		Estep E	Brothers	Fune	ral Service altimore, N	P. A.				
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure, List only one cause on each line.	not ente	r the mode of dying	, such as c	ardiac or	respiratory arre	est,		Approximate Interval Between		
-	Physician/		Immediate Cause (Final disease or condition	0	been					•	Onset and Death  Muss 145		
	Medical Examiner		resulting in death)  Due to (or as a construence	of):									
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876	tificat ng ph as th	Med	IF FEMALE:										
Box 687	th cer tendii or use	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live Birth 2 Fetal dea		Ectopic pregnancy	/				ate of delive	,		
Bo	e deat the at hed fo	Physician/Me	1  Yes 2 No 4 Pregnant at time of death 9 Unknown	5 ∟	Other (specify)				IVI	onth	Day Year		
P.0.	at the set by detac		Part II. Other significant conditions contributing to death but not resulting	in the u	nderlying cause give	en in Part I.		23e. Did to	bacco use con	tribute to th	ne cause of death?		
S,	ires t sign	d by						1 □ Y	es 2 🗆 No	3 🗌 Prob	pably 4. Unknown		
ord	v requ	olete						24a. Was a		Were autor	osy findings available		
3ec	sician: The law certificate has b lirector, page 2 s	Completed						autop: perfor 1 \square Yes	med?	prior to cor death? 1  Yes	mpletion of cause of		
a	ian: T	Be C	25. Was case referred to medical examiner?		26. Pla	ce of Death	(Check		2 <del>1</del> 110]	i Lies	2-2- NO		
<del>=</del>	hysic his ce Il direc	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/O		t 3 DOA Other	r: 4 🗆 Nur	sing Hon	ne 5 🗌 Reside	ence 6-0th	er (Specify	IL FT Hospike		
٥	ling P	ate:		Time of injury	28c. Injury work?			8d. Describe ho	w injury occur	red			
Sior	death death stor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Deposite description 28e. Place of Injury - At home, for	arm etre		res 2□1	_	10f Lagation (C)	beneficial Atoms	an an Druml	Davida Murahar		
Division of Vital Records,	after after Direct		4 ☐ Homicide determined building, etc. (Specify)	am, sire	et, ractory, office		2	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical	29a. Certifier 1-Certifying Physician: To the best of my knowledge,	, death o	ccured at the time,	date and pl	lace, and	due to the cau	se(s) and manr	er as state	d.		
	the Ho nin 24 the Fu	Med	(Check 2   Medical Examiner: On the basis of examination and/only one) 3   Certifying Nurse Practioner: To the best of my know	whowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Initiation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated at of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)  The Ly 2 h, 20/0  In (Item 23a) (Type, Print)  Signature									
	<b>2</b> w± 20		29b. Signature and title of certifier		29c. License	number		_ 2	29d. Date signe	d (Month, E	Day, Year)		
			T mb		1))	YO	11		T4/y	, 21	1,2010		
			30. Name and address of person who completed cause of death (Item 23a)	(Type, P	rint)	11- 15	24 /	3/101:	15/6/				
	Stat	e	31. Date filed (Month, Day, Year)  32. Registrar's Signature		3 7 /20	0/1	F Em	, , , ,	1001				
	Registra		111 292010	6 1	backer			_					

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Physician Month 0745 A Pauline D. Williams 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Baltimore 2536 West Lanvale Street If Under 1 Year | If Under 24 Hrs. | 8. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1 □ M 2 □ F Director 218-26-2126 Oct 17, 1927 No. Carolina Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f show Director 1 DeYes 2 □ No N/A **Baltimore** Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 2536 West Lanvale Street 21216 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, If a Made once. Elementary/Secondary (0-12) College (1-4or 5+) Hospital Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martha Hines Louis Hines ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2536 West Lanvale Street Baltimore, Maryland 21216 Bernard Williams 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 08/02/10 Owings Mills, Md. Garrison Forest Veterans Cemetery of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A.

23a. Part1. Enter the kilbease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. Severe 20 years chronic obstructive pulmonary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Ye ar 4 ☐ Pregnant at time of death 5 ☐ Other (specify) □Yes 2⊠No signed by the a d be detached f P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 No Division of Vital 1 ☐ Yes 1 TYes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending Injury 124 hours after death.

le Funeral Director; A
bletely filled in by the ft 1 ☐Yes 2 ☐ No death. investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MID LATTENDING MP D415 26,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #650. Baltimore, mp 21218 Peter Sloanz MB 3333N Calvero 54. 31. Date filed (Month, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 0 1 0

			for State Registrar	State of Maryland		tificate of			eg. No.	23010		
	Physicia		1. Decedent's Name (First, Middle, Last) Olga E. Allen	2. Date of Deat July 2:	1, Day 2010 e	3. Time of Death 5:35A. M						
1	/Medic Examin		4a. Facility Name (If not institution, give so Renaissance Gardens at	reet and number) Riderwood Village	e.	4b. City, Town, o Silver	Location of Death Spring		4c. County of D	nce George's		
	Funeral Director		5. Social Security Number 6. Sex 056-40-5533 1□	M 2 F 7. Age (In yrs. I.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day) Aug • 9, 1	915 Ma	Birthplace (State or Foreign Country) SSACHUSETTS		
Maryland a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince Ge		10d. Inside City Limits 1 □ Yes 2 No								
4	3a or 28	al Dire	10e. Street and Number 3160 Gracefield Ro	ad, #3319		10f. Zip Code 20904		1	Og. Citizen of Wha United			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examination to the reduced at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in U.S Armed Forces? 1		Nas Decedent of H f Yes, specify Cub l □ Yes 2 XNo	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		American Indian, White, etc. White			
	ompleted	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed)  College (1-4or 5+)	16a. Deced (Give life. L Homer		oation during most of work d)	king	own home				
	To Be C	17. Father's Name (First, Middle, Last)  Ignaz Wowk		1		Niedokia	Oduplak					
, Mar	and 2 sho salth and 27 is ma er trauma		19a. Informant's Name/Relationship (Type Martha A. Gordon -	daughter	4701	St. Mary	s Street	Beltsvi		<b>l</b> and 20705		
Baltimore,	rages I ament of He ant: If iten ury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State  20b. P	lace of Dispo emetery, cren copoli	sition (Name of natory or other pla tan Crema	atory 7/2		20c. Location - Cit Alexandri	y or Town, State La, Virginia		
Balt	Depart Import any inj once.		21. Signature of Funeral Service License		Maryland 20705							
	hysician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	eations that caused the death e cause on each line.  Parkinson's  Due to (or as a consequ	s Disea		ng, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death Years		
	xaminer	niner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events									
68760,	incate be executed ig physician and as the burial-transit	Medical Examiner										
ecords, P.O. Box 68760,	by the attending platached for use as t	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		23d. Date o			
ds, P.	unes trat in 1 signed by 1d be detacl		Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause gi	ven in Part I.		Did tobacco use contribute to the cause of deal			
m g	ate h	Completed					- na na na na na na na na na na na na na	24a. Was a autop perfoi 1 □Yes	sy prid rmed? dea	re autopsy findings available or to completion of cause of ath?  Yes *\sum_No		
Vita	certific ector,	Be (	25. Was case referred to medical examiner?	ospital:		Oti		th (Check only o				
on of	After this funeral dir	ion: To	27. Manner of Death 12 Natural 5 Pending	1 ☐ Inpatient 2 ☐  28a. Date of Injury  (Month, Day, Year)	28b. Time of Injury	f 28c. Inju	4 AJ Nursing F	1	dence 6 Other now injury occurred	(Specify)		
Sic ten teat tor: the	Certification: To	2 Accident investigation 3 Sulcide 6 Could not be 4 Homicide determined	Street and Number vn, State)	or Rural Route Number,								
	within 24 hours after of Age to the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 Acertifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the to	ime, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and mann date and place, an	ner as stated. d due to the cause(s)		
1	withir To th comp	Me	29b. Signature and little of certifier			29c. Licen D24				I. Date signed (Month, Day, Year) uly 21, 2010		
			30. Name and address of person who con E.J. Machado, M.D.				r Spring,	Marylan	nd 20904			

State Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State o	f Marylar	•	artmer <i>tificati</i>			and M	ental Hy	gien	0.0	I N	23	67	7
П		,	1. Decedent's Name (First, Middle	e, Last)							2. Date of De	eath			3. Time	of Death	
	Physicia Medi		Gertrude					Aron	son		July 1	2,	2010	Year	3:00	a	М
*	Examir		4a. Facility Name (if not institution				4b. City,	Town, or	Location o	f Death		4	c. County	of Death			
			Potomac Valley 5. Social Security Number			land frieth day)	Rock If Under	vill	e If Under 2	24 Um 1	0.0-1(0)		Montg				
	Funeral Director		229-44-7378 Usual Residence of Decedent	1 ☐ M 2 ☐ <b>X</b> F	7. Age (In yrs. I	Yrs.	Months	Days	Hours		8. Date of Bil ( <i>Month, Di</i> 11/13/			9. Birthi Coun Virg	olace (State try) inia	or Fore	gn —
0	show at	ğ	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							1	0d. Inside (	City Limi	ts
1	Aaryla 8a-f s tiffied	Director	Maryland Montgo	omery	Roc	kv <b>i</b> lle	<u>:</u>								1 🖾 Ye	es 2 🗆	No
	a or 2 be no	Ξ	10e. Street and Number				10f. Zip	Code	- "			10g. C	Citizen of W	/hat Cour	itry?	•	
	h with	Funeral	1235 Potomac Va	alley Road				208						USA			
	r iten iner r	/Fu	11. Marital Status	Armed For		S. 13. \	Was Deced f Yes, spec	dent of His cify Cubar	spanic Orig n, Mexican,	gin? (Spec , Puerto R	ify Yes or No- ican, etc.)			e - Americ	an Indian, etc.		
336	al", o	d by	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 🎛 Divorced	If You Cive	•	1	□ Yes	2 🕱 No	Specify:				Specify:		White		
21215-0036	hours natur ical i	Completed		nt's Education	163.	16a. Deced	lent's Usua	al Occupa	ation			16b.	Kind of Bu				
218	in 72 e. <b>man</b> "l	l mc	(Specify only high Elementary/Seconday (0-12)	est grade completed) College (1-	4 or 5+)	life. D	O NOT use	e retired)	uring most	of working	g				_ ′		
21	J with ygien her th	Be C		4		Retai	1 Sa1	es C	lerk			Ma	jor D	epar	tment	Sto	re
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Me Iteal Examiner must be notified at	To B	17. Father's Name (First, Middle,  Isadore Adler	Last)				Ì		r's Name ie S	(First, Middle, iman	Maider	Surname,	)			
ž	ould b d Mea mark maric		19a. Informant's Name/Relations	hin (Timo, Print)		1401 14 75											
Ma	2 sho Ith an 27 is trau	П			aughtor		-				Route Numbe					0015	
ē	t of Heal		Jacqueline C. A 20a. Method of Disposition	tronson, u	20b. F	Place of Dispo	sition (Nan	ne of	- 1		. 420 <b>.</b> ate		Location -			0813	
			1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		State Bet	emetery, cren h Jose Iom Cen	natory or o	ther place udat	h l	7/14	/2010	l			nty,	7Δ	
alti	平年任语		21. Signature of Funeral Service		19110			•								V ZI	
ä	permi Depar Impo any ir		- Carettin		MO125	5 1	ANZAN 170 R	lockv	ille	Pike	MEMORI , Rock	vil.	le <u>, M</u>	LS, aryl	and 1	2085	2
			23a. Part 1. E er the disease, of shock, or heart failure. List of	complications that conly one cause on each	aused the deat	h. Do not ente	er the mod	e of dying	g, such as o	cardiac or	respiratory a	rest,			Approxima		
J.	hysician/		Immediate Cause (Final disease or condition	Pneur											Onset and Weel	Death	
	Medical Examiner		resulting in death)		or as a consequ	uence of):											
	LAdillilei	<u>.</u>	Sequentially list conditions,	b. Demen										_	l year	<u> </u>	
	0 1	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	പണരം ഗ്യ.								1					
	and and	Exal	that initiated events resulting in death) Last	c. Due to (c	or as a consequ	uence of):								$\dashv$			
0	te be exe tysician a ne burial-	g	,														
09/89	Attending Physician: The law requires that the death certificate be executed at death.  The death.  The first this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transfer.	Physician/Medical		d													
89	eath certificate attending phy I for use as the	N N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	ome of pregna		Ectopic p	arean an a	,			Į	23d. Date	e of delive	ery		
Вох	death ie atte	sicie	in the past 12 months? 1 Yes 2 Xo		ant at time of		Other (sp		y 				Mor	ith	Day	Year	
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/ita	ysician: is certific director,	To Be	examiner?  1 \( \sum \) Yes 2 \( \bar{\mathbb{K}} \) No	Hospital:	npatient 2 🗆	FR/O.tti	+ 2 \( \bar{\pi}\)	Othe	r:								
of Vital Records,	g Phy er this eral o		27. Manner of Death	28a. Date o	f injury	28b. Time of		8c. Injury	at		e 5 Resi						_
nc	offending death. ctor: Afte y the fun	cat	1 XNatural 5 ☐ Pendir 2 ☐ AccidentInvesti	gation	n, Day, Year)	injury	М	work?	Yes 2 🗌	No							
Division	r Atte ter de recto by th	Certificate:	3 Suicide 6 Could 4 Homicide determ	ined 28e. Place	of Injury - At ho		et, factory	, office		28	3f. Location (			r or Rurai	Route Num	ber,	
á,	ıtal o ırs afı ral Di			V)													
	e Hospital or Attend 124 hours after death E Funeral Director. A leted filled in by the f	Medical	(Check 2 Medical E	Physician: To the be xaminer: On the basis	s of examination	n and/or invest	igation, in r	my opinior	n, death occ	curred at the	ne time, date a	and plac	e, and due	to the cau	ise(s) and m	anner st	ated.
:	Io the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completed filled in by the funer	ž	only one) 3 L Certifying 29b. Signature and title of certifie	Nurse Practioner: T	o the best of my	y knowledge, o		red at the . License		and place,	and due to th		(s) and mar ate signed				_
	-		) Kt - 01	A de	0012	200		3826					12				
	3		30. Name and address of person	who completed cause	of death (Item	1 23a) (Type. P	rint)		_								
			Dr. Anurita Me				,	Rese	arch	B1vd	, Rock	v <b>i</b> 11	le, M	D 2	0850		
	Sta	te	31. Date filed (Month, Day, Year)		gistrar's Signa		Ked						-				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Lagible.)

AMEND ITEM#17perFH, G905, 7/29/2010, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 219 Ella Welch Way Lothian, MD 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🖺 F July 28, Months Days Hours Min. York, PA 1948 167-40-6646 Director 61 Yrs Usual Residence of Decedent , or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No MD Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 219 Ella Welch Way 20711 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 - Widowed 4 T Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12)  $10 \, {
m th}$ College (1-4 or 5+) Homemaker Domestic Be Charles Daniel Forry
Charles DanielForry 18. Mother's Name (First, Middle, Maiden Surname) ഉ Miriam Nickol 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa_Turbaugh 20711 219 Ella Way, Lothian, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Denial 2 Cremation 3 Removal from State a Memorial Susquehanna 4 ☐ Donation 5 ☐ Other (Specify) Julv 21 2010 York, PA 134 W Brondway, Red DUN PA 17552 Signature of Funeral Service Licen 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending the second Cause (Disease or iinjury that initiated events been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Year Pregnant at time of death 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a Was an 24b. Were autopsy findings available To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.9 autopsy performed? Yes 2 No prior to completion of cause of death? 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital Other: 유 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 A Natura 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accider
3 Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title 29c. License number ted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co

Registrar

Months

Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

State of Maryland / Department of Health and M

7. Age (In yrs. last birthday)

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

Doris Ann Barrack

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

1 □ M 2 🖫 F

**Physician** 

/Medical

Examiner

**Funeral** 

e Ink. Ensure All Copies Are Legible. t of Health and Mental Hygiene											
e of Death	ieniai ny		No.20	10	23679						
	2. Date of Do		Pay/20:	L Ö ^{ear}	3. Time of Death 5:50 am						
Town, or Location of Death Prince Frede	rick		4c. County of Death Calvert								
1 Year   If Under 24 Hrs.   Days   Hours   Min.	8. Date of Bi (Month, D 08/08/	rth PY 9	26	9. Birth Cou	place (State or Foreign intry) DC						
					10d. Inside City Limits 1 □ Yes 2 👿 No						
20736		10g	10g. Citizen of What Country? U.S.A.								
lent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - American Indian, Black, White, etc.  Specify: White								
al Occupation k done during most of worki e retired) Packing	ng	î.	16b. Kind of Business/Industry  Manufacturing								
18. Mother's Name Grace	(First, Middle Spicer		den Surnan	ne)							
(Street and Number or Rura	_			. <i>State, Z</i> 736	ip Code)						
ther place)	7/2010		20c. Location - City or Town, State  Brentwook, MD								
d Address of Facility Lee Southern Md B	e Funer lvd., (	cal Owi	Home	Cal MD 2	vert, P.A. 0736						
e of dying, such as cardiac o	or respiratory	arrest	1		Approximate Interval Between Onset and Death						

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director:

23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy past 12 mgnths?  'es 2- No  23c. If yes, outcome of pregnancy 1										
Part II. Other significant conditions of	ontributing to death but not resulting ir	n the underlying car	use given in Part I.			se contribute to the cause of death?  No 3 Probably 4 Unknow	۷n				
				24a. Was auto perfo 1 □ Yes	psy ormed2	24b. Were autopsy findings availab prior to completion of cause o death? 1 □Yes 2 □ No					
25. Was case referred to medical	26. Place of Death (Check only one)										
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	itpatient 3 DOA	lome 5 ☐ Resi	e 5 ☐ Residence 6 ☐ Other (Specify)							
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Time of 28 njury M	c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury	occurred					
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	28f. Location ( City or To	n (Street and Number or Rural Route Number, Town, State)								
29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the best of my knowledge niner: On the basis of examination an and manner stated.	e, death occurred a d/or investigation,	t the time, date and place in my opinion, death occu	e, and due to the urred at the time,	cause(s) date and	and manner as stated. place, and due to the cause(s)					
29b. Signature and title of certifier		29c.	License number		29d. Date	e signed (Month, Day, Year)					

PIZINCE FILED BILICK,

State Registrar

dRW

31. Date filed (Month. Day.

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 HOSP 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 23680 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 1159AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mary tois ta1 eonard 401 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Hours Director 92 228-05-2635 Usual Residence of Decedent show should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f shor oortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland St. Mary's Loveville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20656 40383 Lenny Penny Lane USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗶 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 X Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Beer Distribution 12 Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Byroads Viola Pettitt permit, Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Gonzalez/daughter Lenny Penny Lane Loveville, MD 20656 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place. Resurrection Cemetery 7/23/10 Clinton, Maryland Signature of Funeral Service Licensee Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. M00817 P.O. Box 128 Charlotte Hall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ system Organ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 9 Unknown eral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 🗷 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 🔀 Natural injury 5 Pending 2 Accident 3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nursa Franticiant T. It is constituted and place, and due to the cause(s) and manner stated. (Check within 2 To the I 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

July 20, 2010

Registrar
DHMH 17 Rev 7/2009

State

ertz,

St. Barys Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010 32.

31. Date filed (Month, Dallar)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 14 ay Mary Jane Boulden 2010 6:36pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Hospital Cecil E1kton 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** ^{Year}1943 Days Mar. 27 1 □ M 2 🕱 F Hours Min. 214-44-4693 67 Director PA Usual Residence of Decedent or 28a-f shov 10a. State with the Maryland 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director E1kton 1 Yes 2 XNo Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 63 Merion Ct. 21921 USA death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married ģ Maryland 21215-0036 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Completed 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 72 permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "any finury or other traumatic event, the Mee College (1-4 or 5+) Elementary/Seconday (0-12) State Government Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Urie Boulden Sr. Minnie Sweetman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Quaile/ husband Elkton, MD 21921 63 Merion Ct. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation Other (Specify) Bethel Cemetery 7/19/2010 Chesapeake City, MD Signal Te of Juneral 22. Name and Address of Facility
R.T. Foard and Gee
259 E. Main St. Elkton 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. auch as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 No Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? P Hospital Other: 1 🗌 Yes 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Natural work Accident 1 Tes 2 🗆 No Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated of certifier 29b. Signatu Day, Year) 29d. Date sign and address of person who completed cause of death (Item 23a) (Type, Print) 10 dimonso 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#18&19a, perFH, G905, 7/307 2010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY Physician/ BISHUP LUNETTE 1:03 A M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORF If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 218-23-4452 51 Months Hours Min. TRINIDAD 9 **Director** Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location Upper Marlboro item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director Prince George's MD 1 X Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 20774 534 Lubentia Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces 1 No Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Media once. (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pvt Nursing Asst. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elcina Louis Bishop Kelvin Lewis 19a. Informant's Name/Relationship (Type, Print)
Angelina Bishop/sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 20785 Cheverly, 3126 Laurel Ave. Angela 20c. Location - City or Town, State Beltsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory 7/21/2010 4 Donation 5 Other (Specify) 22 Name and Address of Facility Johnson & Jenkins 716 Kennedy St. N.W. Washington, 21. Signature Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPTICEMIT disease or condition resulting in death) Medical Examiner LYMPHOMA Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has i completed filled in by the funeral director, page 2 s autopsy death? 1 Tyes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No ျ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 1093030546 JULY 13, 2010 SOUTH GREENE ST, BALTIMORE, MO 212 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHUNG MICHAEL

Registrar

filed (Month, Day, Year

JUL 1 6 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #10f&20b&c Per FH G906 8/03/10 JH
State of Maryland / Department of Health and Mental Hygiene 20 10 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Priscilla Elizabeth Bryant 10:47PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George's Doctors Community Hospital Lanham Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2**X** F Months Days Hours Min (Month, Day, Country) **Virgini**a 89 578-20-2644 Director Usual Residence of Decedent show or 28a-f shown notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Lanham P.G. MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be i Funeral 7031 Wood Thrush Drive <del>20801</del> 20706 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc. ò δ 1 Never Married 2 Married African-American If Yes, Give Year or Dates. 1 ☐ Yes 2 XNo Specify: Completed 3 X Widowed 4 □ Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Domestic Worker 12 marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F မ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Charles Harris Stewart Pearl Lena Jones 9a. Informant's Name/Relationship (Type, Print) Son/ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Henry & Jeanne Marshall-Daughter 031 Wood Thrush Drive, Lanham, MD 20801 19a. Informant's Name/Relationship (Type, Print) Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State Suitland, MD. 20b. Place of Disposition (Name of Line of Der Gene transfer) Date N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-21-10 Maryland Nat'l BRYANT 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Licens 22. Name and Address of Facility

Bonnette & Assoc. Funeral Hm 2504 28th St., N.E. 21. Sign 23a. Far 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s wick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIAC ARRYTHMIA disease or condition resulting in death) Medical Due to (or as a consequence of Examiner FAILURE RESPIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). PNEUMONIA attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical CHRONIC OBSTRUCTIVE PULMONARY DISEAS Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONIC KIDNEY DISEASE STAGE FOUR 1 Yes 2 No 3 Probably 4 Unknown Completed LYMPHOMA 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy performed After this certificate has page 2 GASTROINTESTINA BLEEDING 2 1 No 1 Tes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ₺ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural iniury 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) rehari D0064478 July 13, 2010 ANNAPOLIS ROAD Suite 200 Dale, MARYLAND 20760 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FISEHATSION MEHARI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 6 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23684 Reg. No [ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ()5555AM MARY ANN BROOKS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Doctors Community Hospital Georges Lanham 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) Hours Country) 231-30-2506 Director 78 1932 19 Virginia Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland must be notified at Director MD Lanham Prince Georges 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20706 6825 Trexler Court U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 😾 No Specify: sBeliack Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Domestic the Homemaker Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Brooks Lillie Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reginald E. Brooks - Son 6825 Trexler Court, Lanham, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 7/12/2010 5 Other (Specify) Oakwood Cemetery Richmond, VA 22. Name and Address of Facility Scott's Funeral Home 21. Signature of Fineral Service Lic 23222 115 E. Brookland Pk Blvd., Richmond, VA 23a. Part 1. Enter the dise shock, or thart failure Immediate Carse (Final disease or condition resulting in leath) ne disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Interval Between Physician/ Sebsis Medical a consequence of): **Examiner** umonio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Condio Vus cular dis-lase been signed by the attending physician and should be detached for use as the burial-transit bertensive Due to (or as a consequence of resulting in death) Last Completed by Physician/Medical Stroke Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 1 ☐ Yes 2 ¥ 9 ☐ Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performe the Hospital or Attending Physician: The Yes 2 No 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, it 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2. No Other: ျ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 2010 - avoila 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gallant Fox LANE, Suitezzz Bowie My 20715 4300 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Day 4:00 PM 2010 1050 BRUSK Dh /Medical 4a. Facility Name (If not institution, give street and nur 4c. County of Death 4b. City. Town, or Location of Death Examiner opper Ridge Carroll md 21784 Kesuille If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 1**∑** M 2 □ F 1925 Director 84 Massachusetts 044-20-6979 Sept 16, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 1 ☐ Yes 2X No Examiner must be notified Director Sharpsburg Maryland Washington 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? ö 21782 U.S.A. 16933 Shepherdstown Pike or Items 23a Funeral 12, Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1943-14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced White 1946 natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) the Federal Government Accountant Department of Health and Mental Hygie Important: If Item 27 Is marked other i any Injury or other traumatic event, tt once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Retty Raer John Brusky ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16933 Shepherdstown Pike Sharpsburg, Maryland 21782 Phyllis M. Brusky / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07-19-2010 Frederick. Maryland Stauffer Crematory 21. Signature of Funeral Service Liceus 22. Name and Address of Facility Bast-Stauffer Funeral Home. PA 7606 Old National Pike Boonsboro. MD 21713 23a. Part1. Effer the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediat Cause (Final disease or condition resulting in death)

a. Due to (or as a concentration) Approximate Interval Between Onset and Death **Physician** ears /Medical Due to (or as a consequent le of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) this c 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 MNatural 1 ☐ Yes 2 ☐ No 2 Accident after death | Director: ... d in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled ir 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

SH 5+1

State Registrar

Year JUL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Jonnie 31. Date filed (Month, Day,

OPPER RIDGE, 710 Obrecht Rd, Sykesville 32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State	partment of Health and ertificate of Death	/ 1	010 23686					
		Ţ	1. Decedent's Name (First, Middle, Last)	stineate of Beatif	Reg. No.	3. Time of Death					
	Physicia Medic	al	ROBERT P. CUTTER  4a. Facility Name (if not institution, give street and number)	Tu 00 T	July 24	2000 19:02 м					
	Examin	er	wm RmC	4b. City, Town, or Location of Death  Cumber/	6)11.00.01111						
	Funeral Director	П	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 214-30-9880 1 🕅 M 2 □ F 78 Yrs.	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Day, Year)	Birth place (State or Foreign Country)					
	>	,	Usual Residence of Decedent		02-04-1932	MARYLAND					
	aryland ba-f show ified at	ectol	10a. State 10b. County 10c. City, Town or I			10d. Inside City Limits 1 ☐ Yes 2 💢 No					
oq.	e filed within 72 hours after death with the Manyland at a Hygiene. Act of ther than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 20511 KLONDIKE ROAD	10f. Zip Code 21532	10g. Citizen o	of What Country?					
	eath wir tems 2: er must	-une	11 Marital Status 12, Was Decedent Ever in U.S. 13	3. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No- 14. R	ace - American Indian,					
9	after de il", or it xamine	by	Armed Forces?  1 □ Never Married 2 M Married  1 □ Yes 2 M No If Yes, Give  Very or Dates	If Yes, specify Cuban, Mexican, Puert  1 Yes 2 No Specify:		Black, White, etc. Specify: WHTTE					
ა-იივი	hours 'natura'	Completed	15. Decedent's Education 16a. Dec	ting 16b. Kind of	6b. Kind of Business Industry						
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ore,	ge 1 and 2 should be nt of Health and Men If item 27 is marke or other traumatic			position (Name of rematory or other place)	Date 20c. Location	n - City or Town, State					
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מ	permit. Departr Imports any inju	a s	1 m 6 15 mon 57/2	SC 60 W MAIN ST FROST	WERS FUNERAL H BURG, MD 21532	OME, P.A.					
ĺ			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death					
j	Medical	0	disease or condition resulting in death)  a. Due to (or as a conse uence of):	HEARY PAIL	URE						
	Examiner	e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	ARTERY DI	SEASE						
	ansit	amin	cause. Chisease or linjury that initiated events  C			, l					
	te be executed hysician and he burial-transi	dical Examiner	resulting in death) Last Due to (or as a consequence of):								
200	ficate b g physi as the b		d								
00 X	th certi ttending or use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1 ☐ Live Birth 2 ☐ Fetal death 3			Date of delivery Month Day Year					
DOX	the dea by the a ached f	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	i □ Other (specify)							
τ. Ο	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	l by P	Part II. Other significant conditions contributing to death but not resulting in the			ontribute to the cause of death?					
ecords,	require	letec	CIAMINSIS LIVER			b. Were autopsy findings available					
Š	The law ate has page 2	Completed by	(100-(100)		autopsy performed? 1 □ Yes 2 □ No	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No					
N La	sician; certific irector,	Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Manatient 2 FR/Outrast	26. Place of Death (Che							
5	ng Phys fter this ineral d	ite: To	1 Ves 2 No 1 Inpatient 2 ER/Outpat  27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time injury	of 28c. Injury at	lome 5 ☐ Residence 6 ☐ 0 28d. Describe how injury occu						
DIVISION OF	Attendi death. ctor: A y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	28f. Location (Street and Num	nber or Rural Route Number.					
2	ital or / irs after ral Dire led in b		4 Homicide determined building, etc. (Specify)		City or Town, State)						
	e Hosp 24 hou e Funer	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge	estigation, in my opinion, death occurred	at the time, date and place, and o	due to the cause(s) and manner stated.					
	To the within To the comp	<	29b. Signature and title of certifier	29c. License number		ned (Month, Day, Year)					
	6		30. Name and address of person who completed cause of death (item 23a) (Type	D26907	JULY	25 2010					
	•		Harrit 5 Sidhu MD 925 Bis	shop Walsh Rd C	lumberland MS	121502					
	Stat Registra	a 31. Date filed (Month, Day, Year) 22. Registrar's Signature									

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State MCDD#12			_					nd Me	ental Hyg	giene	)			
			<ul> <li>State Registrar AMEND#13per</li> <li>Decedent's Name (First, Middle</li> </ul>		2/10,HM	MDCO		ertifica	te of L	eatn		2. Date of Dea	Reg. No	20	_0_	236	87
	ysicia Medic		Joseph Victo	,	Ca	samer	nto					Month  1 u 1 y	9 Da	y 20	Year 10	3. Time of De 11:00 F	
	camin		4a. Facility Name (if not institution,	give street	and number)					Location of I							
Fue	neral		Casey House  5. Social Security Number	6. Sex	7. A	ge (In yrs. I	ast birthda	_	ockvi er 1 Year	LLe _If Under 24	1 Hrs.	8. Date of Birt	_	Monte		J place (State or Fe	oreian
	ector		579-42-7796	1 🖾 M :		78		Months	Days	Hours	Min.	oct. I4	Year	931 W	lash	ington, I	OC
pu	at	or	Usual Residence of Decedent  10a. State 10b. County			10c. Cit	y, Town or	Location							1	0d. Inside City L	Limits
Maryla	tified	Director	Maryland Montgo	omery				Bethe	sda							1 X Yes 2	□No
th the	t be no	al Di	10e. Street and Number	.11 D	1 45	0.537		10f. Z	ip Code	1.			0	tizen of Wi	hat Cour	itry?	
ath wi	r mus	Funeral	5225 N. Pooks H		las Decedent		S. 1	3. Was Dec	208 edent of Hi		n? (Speci	fy Yes or No-	Т		- Americ	an Indian.	
land 21215-0036 be filed within 72 hours after death with the Manyland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho	Examine	by	1 🔀 Never Married 2 🗆 Married 3 🗆 Widowed 4 🗆 Divorced	52-	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  +					14. Race - American Indian, Black, White, etc.  Specify: White							
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e filed ital Hyg	event,	To Be	6										Maiden	Surname)			
Maryland 2 should be filed th and Mental Hy 77 is marked oth	ımatic		Angelo Casam  19a. Informant's Name/Relationsh	19h M	ailing Addre	es (Stroot s				City or	Town Sta	tate, Zip Code)					
, M6 nd2sh salthar n27 is	er trau		Samuel Casament		•			-					-				
<b>Baltimore,</b> permit. Page 1 and Department of Hee Important: If item	ury or oth	1	Samuel Casamento / Brother    Samuel Casamento / Brother   Sill MacArthur Blvd. #3, NW Wash., D.C.   20a. Method of Disposition   Casametric Method of Disposition   Casameter, crematory or other place)   Casameter, crematory or other place)   Casameter, crematory or other place)   Casameter											City or To	or Town, State		
balt permit. Depart	The part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the										3		20				
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-γnysiα ⊢ Meα	dical	1	Immediate Cause (Final disease or condition resulting in death)		Anoxio			opath	У						-	Onset and Dea	1111
Exam			Sequentially list conditions,		Cardio		,	Arre	st								
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rate be executed physician and	al-tran	Еха	that initiated events resulting in death) Last	c. <u> </u>	Due to (or as	s a consequ	uence of):								+		
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oo/ Sertifica Iding pl	se as t	/Me	IF FEMALE:	23c If	ves outcom	e of pregna	incv						$\neg$				
<b>BOX</b> death of	ched for us	Physician/M	3b. Was decedent pregnant in the past 12 months? 1 \( \) Live Birth 2 \( \) Fetal death 3 \( \) Ectopic pregnancy 23d. Date of the past 12 months? 4 \( \) Pregnant at time of death 5 \( \) Other (specify) \( \) Unknown 23d. Date of Month 1 \( \) Unknown									ery Day Yeai	r				
S, F.O. res that the signed by	d be deta	þ	Part II. Other significant condition Atrial Fibrilla		ting to death	but not res	ulting in th	e underlying	ı cause giv	en in Part I.						e cause of deat	
VITAI KECOFOS,  iysician: The law requires is certificate has been sig	shoul	Completed	Chronic Kidney	Disea	ise							24a. Was a		24b. W	ere autor	osy findings avai	ilable
The lar	page 2	Com										autop perfor 1  Yes	sy med? 2 █ No	de	ath?	to completion of cause of 1? Yes 2 \sum No	
ITal sician: certific	rector,	Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☒ No	Hospita	ai:				Othe	ace of Death						TT	
OT V  ig Phys  ter this	eral di	e: To	27. Manner of Death		a. Date of inj	ury	28b. Time		28c. Injury	at Nurs		e 5 Resid				Hospice	
ION tendin leath. or: Aft	the fun	Certificate:	1 🛣 Natural 5 ☐ Pendin 2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could	ation	(Month, D	ay, rear)	injur	М	work	? Yes 2 □ N	о						
DIVISION tal or Attendir rs after death. al Director: Af	d in by		4 Homicide determ		e. Place of In building, e	jury - At ho tc. <i>(Specify</i>		street, facto	ry, office		28	3f. Location (S City or Town			or Rural	Route Number,	
Le Hospita n 24 hours e Funeral	completed filled in by the	Medical	29a. Certifier 1 Certifying (Check 2 Medical E only one) 3 X Certifying	xaminer: Or	n the basis of	examination	n and/or in	estigation, in	n my opinio	n, death occu	urred at th	ne time, date ar	nd place	, and due t	o the cau	ise(s) and manne	er stated.
Vithin to	com	-	29b. Signature and title of certifier	2	17	A			c. License		7			te signed (			
10			30. Name and address of person v	yho comple	ted cause of	<u>,                                     </u>	23a) (Typ		111	5108	5		Jul	y 10	, 20	10	
			Diane Ruckert,	CRNP	6001	Munca	ster	Mill	Rd. I	Rockvi	11e,	MD 20	855				
Re	Stat gistra	e	31. Date filed ( <i>Month, Day, Year</i> ) <b>JUL</b> 15 2	010	2. Regist	rar's Signa	ure	west									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death July 12, Day 2010 Year Physician/ 2:16 p Cordelli Crystal Lorraine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery General Hospital Olney Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Year) 1<u>925</u> 1 □ M 2 🏝 Days Hours July 30, 506-26-1375 84 Nebraska **Director** Usual Residence of Decedent or 28a-f show 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 🏝 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20853 or items 23a 4915 Baffin Bay Lane 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by ☐ Yes 2xxNo Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2x No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N Secretary Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earl Ingraham Elsie Mays 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melanie M. Page/Daughter 17413 Park Mill Drive, Derwood, MD 20855 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 14 2010 Metropolitan Crematory Alexandria, VA 22 Name and Address of Facility ins Funeral Home Inc. Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Signature of Funeral Service Licensee 23a. Part 1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final ABDOMINAL Ph sician/ Rusture D disease or condition Medical resulting in death) Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 moviths? Day Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy page the Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending after death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

Registrar DHMH 17 Rev 7/2009

Medical

29a. Certifier

(Check

only one) 29b. Signature

31. Date filed (Month, Day,

nd address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

HRTHUR SCHOEN 604D

Year)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Paina Philip Drive

D18726

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ 3:25M Richard Andrew CASTLE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Maryland Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 X M 2 🗆 F July 23 Maryland Year 1923 **Director** 214-16-1972 86 Usual Residence of Decedent ian "natural", or items 23a or 28a-f show M dical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Washington Hagerstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21740 U.S.A. 12150 Hopewell Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 

Yes 2 □ No Black, White, etc. þ 1 Never Married 2 K Married 1943 Maryland 21215-0036 If Yes, Give Year or Dates 1 🗌 Yes 2 🔀 No Specify: white 1946 Specify. Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Je filed with...
**tal Hygiene.
**er than "r (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) mechanical engineer truck company of Health and Mental Hygier item 27 is marked other to other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe Andrew C. Castle Mary Barnhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Richard S. Castle - son 12150 Hopewell Road, Hagerstown, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State Hagerstown Crematory July 2010 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Pnysician/ disease or condition Neumones Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine ALHERIA attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 ☐ Live Birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death
9 ☐ Unknown in the past 12 months? Month Day Yes 2 No be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 1 No Other: ျ 1 Yes 1 Marient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify)

Division of Vital Records, P.O. Box 68760

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and the funeral director,

completed filled in by 24 hours To the within 2

Certificate:

Medical

5H 3+1

29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

28c. Injury at

1 Yes 2 No

28d. Describe how injury occurred

City or Town, State

Location (Street and Number or Rural Route Number,

MM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of injury (Month, Day, Year)

ROAD GHAZARA UX. HAGENSTOWN MIK

State Registrar 5 Pending

Investigation 6 Could not be

determined

27. Manner of Death

Natural

2 Accident
3 Suicide

4 Homicide

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

iniury

			For State Registrar	State	of Maryla	ind / Depa	artment of F	lealth ar Death	nd Mental	Hygier Reg. No.	010	23690		
			1. Decedent's Name (First, Mide	tle, Last)					2. Date of	f Death		3. Time of Death		
	Physici		Janys Elizal	oeth Cle	venger				July	17.	2010	9:30 P M		
1	/Medic Examir		4a. Facility Name (If not instituti				4b. City, Town, o	r Location of			County of Death			
	LXaiiii		Julia Manor H	ealth Care			Hagerst	own		V	Vashingt	on		
	Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Under 1 Year	If Under 24		f Birth		aplace (State or Foreign untry)		
	Director		220-16-1959	1 □ M 2 💢 F	85	Yrs.	Months Days	Hours		1, Day, Year) 10 192		1and		
	7		Usual Residence of Decedent											
	nylan how		10a. State 10b. Coun	У	10c. (	City, Town or Lo	ecation					10d. Inside City Limits		
	Ma Ma	ō	Maryland Wash	ington	H	agersto	wn					1 Yes 2 □ No		
	# 128	Directo	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Co	untry?		
	23a (23a)		333 Mill St.				21740			U.S	J.S.A.			
	n 72 hours after death with the Maryland "naturel", or iteme 23s or 28s-f show edical Examinar must be notified at	Funeral	11. Marital Status	12. Was Dec	cedent Ever in	U.S. 13.	Was Decedent of H	lispanic Origin	n? (Specify Yes of	r No- 1	14. Race - Amer Black, White			
٥	after or its		1 Never Married 2 ☐ Ma	rned 1 Tyes	2 No live Dates:	1	1 ☐ Yes 2 X No	Specify:	oono moun, oro			s, etc.		
215-0036	ref.	d by	3 ☐ Widowed 4 ☐ Divorce	d Year or	Dates:		10163 2410	эрвспу.			Specify: Wh	nite		
ה	I within 72 ho iene. r then "natur ihe Medical	Completed		ent's Education est grade completed	)		dent's Usual Occup kind of work done		of working	16b. Kir	nd of Business/I	ndustry		
N	within 72 ene. then "nat	ig.	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retired	d)						
	filed wi Hygien sther th	S	8				Driver			Tr	ansport	ation		
Maryland 2	be filed htal Hygid od other event, II	Be (	17. Father's Name (First, Middle	, Last)				18. Mother's	s Name (First, Mi	ddle, Maiden .	Sumame)			
<u>a</u>	should be and Mental marked o	2	James Sidney (	Clevenger				Georg	gia Eik.	Leberge	r			
E.	and and le mu		19a. Informant's Name/Relation	ship (Type, Print)		19b. Maili	ng Address (Street	and Number	or Rural Route N	umber, City or	Town, State, Z	ip Code)		
	s 1 and 2 should of Health and Men item 27 is marks other traumatic	N .	S. Craig Cleve	enger / Br	other	2080	7 Old For	ge Rd.	Hagers	own Ma	ryland	21742		
ğ	iges 1 at of He if item or oth	. 8	20a. Method of Disposition			. Place of Dispo	sition (Name of natory or other place		Date		cation - City or			
saltimore,	Pages nent of int: If it iry or o		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other			•		. 1	20/2010	Hager	stown.	Maryland		
<b>=</b>	permit. Pag Department Important: I eny injury o	6	21. Signav re uneral Service	B Licen e			. Name and Addre							
ñ	Per Per S		1	Van	~							yland 21742		
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that	caused the de							Approximate Interval Between		
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	(or as a cons	,	abstr	w.Tw	c Lyr	90	Peak	Onset and Death		
		ě	Sequentially list conditions,	Dug to	(or as a cons	equence of).		, , ,						
	uted d ansit	Examin	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1										
,	be executed icien and burial-transit	Exa	resulting in death) Last	Due to	equence of):									
9/e	e be /sicie e bur	dical												
ĝ	certificate nding phys use as the	edi												
C. BOX	atte for u	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐ Live 4 ☐ Preg	23c. If yes, outcome of pregnancy  1  Live birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)							23d. Date of delivery Month Day Year		
s, J	n requires that the de been signed by the s should be detached	by Pi	Part If. Other significant condi-	ions contributing to	death but not r	esulting in the u	nderlying cause giv	ren in Part f.	23e.	Did tobacco u	se contribute to	the cause of death?		
Vital Records,	en si ould I									1 ☐ Yes 2 ☐	□No 3 □ Pro	obably 4 Durknown		
ပ္က	law rees be	Completed								Was an	24b. Were au	topsy findings available completion of cause of		
ř	0 5 0	Eo								autopsy performed? es 2 No	death?	-		
ā	ilcian: Th certificate rector, pag	0	25. Was case referred to medic	al				26 Place o	of Death (Check of		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 140		
	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	☐ ER/Outpatier	t 3 DOA Oth		sing Home 5		Other /See	2/6/1		
Ö	Phys er this eral di	<u>-</u>	27. Manner of Death	28a, Date	of Injury	28b. Time o				ribe how injury				
UIVISION	Attending I r death, ector: After by the funer	Certification:	1 ☑Natural 5 ☐ Pend 2 ☐ Accident inves	ling (Mo tigation	nth, Day Year)	Injury		k? Yes 2∐No	0					
2	Attender death	100	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 286. Place	e of Injury - At	home, farm, sti	eet, factory, office					ral Route Number,		
S	s afte	ert	4   Hornicide	Dulk	ding, etc. (Spe	icity)			City o	r Town, State)				
	To the Hospital or Atti within 24 hours after de To the Funerel Direct completely filled in by the	edicai (	29a. Certifier 1 Certify (Check only 2 Medical	ing Physician: To the Il Examiner: On the and ma	ne best of my k basis of exami nner stated.	nowledge, deat ination and/or in	occurred at the tirvestigation, in my o	me, date and pinion, death	place, and due to occurred at the t	the cause(s) ime, date and	and manner as place, and due	stated to the cause(s)		
	To th To th Comp	Me	29b. Signature and title of certif				29c. Licens		,	29d. Date	e signed (Monti	h, Day, Year)		
			Fam	of the same	4/		De	060	396	7	11911	0		
		1	30. Name and address of perso	n who completed car	use of death (It	tem 23a) (Tyne	Print) •			-1	h			
51	1-1		FARIN	MYN		D	(	1.70	0 (	al	c 1	21740		
	Sta	ite	31. Date filed (Month, Day, Yea	r)   32.	Pagistrar's Sig	nature		14 -	Alucte	VV	mn	21740		
	Registr		JUL 1	9 2010	Long	A	all	(4) 0-	gras 1	1	,	- 1		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ John James Daras 2010 Tu 1 v 12:05a Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** St. Mary's Scotland 5 4 1 15092 Chesapeake Bay Drive 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 □ F Months Days Hours Min. 88 Director 577-12-0163 1922 Vashington. May 15. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 28a-f 1 ☐ Yes 2XXNo Maryland Prince Georges Accokeek 10f. Zip Code ò 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 15301 Poplar Hill Dr. 20607 USA be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, rmed Forces?
X Yes 2 \( \subseteq \text{No} \) Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1943–1945 1 ☐ Yes 2 🔀 No Specify: "natural", Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) <u>Federal Government</u> <u>Grocer</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever မ James Daras Sylvia Butler Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Paula Franks/Daughter 2009 Tundra Court, Annapolis, Maryland 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 07/22/2010 Cheltenham, MD 21. Signature of Funedal Service License 22. Name and Address of Facility Brinsfield-Echols 30195 Three Notch Funeral Home, P.A. Rd., Charlotte Hall, MD 20622 A 23a. Part 1. Ent. If the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-transi Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy Live Birth ∠ 🗀 , o.... _ Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this eral Director: After th filled in by the funeral 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, decar of the cause (s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) eme of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre Jennifer Schmidt, DO, 40900 Merchant Lane, Leonardtown, MD 20650 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Baltimore,

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra AMFND#20 lopenFH, 7/20/10, BMN, McCo 23692 Certificate of Death 2. Date of Death July 5, 2010 Physician/ 10:00 AM Charlotte Hoelman Devine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 13112 Dumbarton Drive Montgomery Rockville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** July 14,1928 Washington D.C. 1 ☐ M 2 🗓 F Months Days Hours Min. 213-54-7953 81 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehrong any injury or other traumatic event, the Medical Eventual Property. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Rockville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13112 Dumbarton Drive 20853 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc. by 1 Never Married 2 Married If Yes, Give Year or Dates. 1 ☐ Yes 2 🕅 No Specify: White Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Hoelman Gladys Albey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Devine (Son) 13112 Dumbarton Drive Rockville, MD 20853 July Date 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Metropolitan Crematory 2010 1 

Burial 2 

Cremation 3 

Removal from State Alexandria, VA 4 Donation 5 Other (Specify) Signature of Funeral Service 22. Name and Address of Facility DeVol Funeral Home der 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 6 Months Metastatic Adeno Carcinoma Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner 2 Years Unknown Primary Secure tially list or writing a Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Bronchitis due to Smoking 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 K No within 24 hours after death.

To the Funeral Director; After this certificate to completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at X Natural 5 Pending work 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D52382 July 6, 2010

State Registrar 30. Name and address of person who

31. Date filed (Month, Day, Year,

Dr. Danilo Molieri M.D.

15

6410 Rockledge Drive #625

Bethesda, MD 20817

completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend 29c per DVR G906 8/9/10 dk

State of Maryland / Department of Health and Mental Hygiene 0 | 0 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 9, 2010 Jayden Jeremiah Dunkley 10:10 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🕱 M 2 🗆 F Min. Months July 9, 2010 O yrs. Days 18 surs Maryland none Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland P.G. Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11443 Cherry Hill Road, Apt. 303 20705 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian 1 🕱 Never Married 2 🗆 Married Black, White, etc. Completed by 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black If Yes, Give Specify. 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jeremane Owen Dunkley Kerry Ann Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kerry Ann Scott/Mother 11443 Cherry Hill Road, Apt. 303, Beltsville, MD 20705 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth Date 20c. Location - City or Town, State 1 🙀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) July 15 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2010 Silver Spring, Maryland 72 Name and Address of Islin's Funeral Home Inc. Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Funeral Service Lice 23a. Part 1. Enter the disease, or shock, or heart failure. List or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the bne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiorespiratory Arrest disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pulmonary Hypoplasia 18 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) the attending physician an hed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Preterm by 26.5 weeks Due to (or as a consequence of) resulting in death) Last Physician/Medical Premature Rupture of Membranes at 19 weeks Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached to q Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Persistent Pulmonary Hypertension of the Newborn, Sepsis, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hypotensian 24a Was an autopsy performed? 1 ☐ Yes 2 ☐ No ∐Yes 2 😿 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 💢 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pendina 2 Accident
3 Suicide 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D31315 07-10-2010

State

Registrar

T-AB/O

31. Date filed (Month, Day, Year)

JUL

OIARTE

15

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 FURCST GIEN RO. SILVER SPRING: MD Holy Cross HospitaL - NICU

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of Ma		epartment of Certificate of		nd Mental H	ygiene 0	10	23694	
/Mo	sicia edica	n il	1. Decedent's Name (First, Middle, 4a. Facility Name (If not institution,		C	4b. City, Town,	or Location of	2. Date of Death	Day  15  4c. County	Year ONO of Death	3. Time of Death	
	mine		The Johns Hopkins	Hospital	e (In yrs. last birtho	Baltimor	r If Under 2	4 Hrs. 8. Date of E	lirth	9. Birthp	lace (State or Foreign	
Fune: Direct			220-85-8186 Usual Residence of Decedent	1 □ M 2 🛣 F	Yrs	s. Months Day	s Hours	Sept.	24, 2009		Lngton, D.C.	
Marylanda-f show	100	.	Maryland Washin	gton	10c. City, Town of Hagerst		10d. Inside City Limits 1X Yes 2 □ No					
with the 3a or 28		ਕ ∣	10e. Street and Number 123 1/2 South L	ocust Stree	t	10f. Zip-Code 2174			10g. Citizen of V	What Count	try?	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Medical Examiner must be notified at	Value III	by Funeral	11. Marital Status  1    Mever Married 2   Marrie  3   Widowed 4   Divorced	12. Was Decedent I Armed Forces? d 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	Ever in U.S.	13. Was Decedent of If Yes, specify Cu		in? (Specify Yes or N Puerto Rican, etc.)	lo- 14. Rac Bla Specii	ce - America ck, White, e fy: whi	etc.	
21215-0036  ed within 72 hours aft giene. er than "natural", or the Medical Examir		Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		(0	ecedent's Usual Occ Give kind of work dor fe. DO NOT use retii	e during most	of working	i	sb. Kind of Business/Industry		
faryland 212. 2 should be filed within and Mental Hygiene. is marked other the Men	a calli, iii	Be	17. Father's Name (First, Middle, La		<u>, , , , , , , , , , , , , , , , , , , </u>		18. Mother	's Name (First, Midd	lle, Maiden Surnai			
Maryland nd 2 should be file alth and Mental Hy 27 is marked oth		2 │	Nicholas Ryan  19a. Informant's Name/Relationshi	p (Type. Print)		Mailing Address (Stre		r or Rural Route Nun	nber, City or Town	, State, Zip		
Te, Marth a Health a tem 27 is		-	Hollie Ann Will  20a. Method of Disposition	ard 	20b. Place of D	3 1/2 Sout	1	Date	20c. Location		2140	
Baltimore, N permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr			1 ★ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Spo	ecify)		ill Cemete 22. Name and Add	ry	July 2010	Hagerst		Maryland	
Dermi Depa	once		21. Signature of Funeral Service Lic 23a. Part 1. Enter the disease, or c	unt		415 East	Wilson	Blvd., Ha	agerstown		ryland 21740  Approximate	
760, ate be executed EX Physician and unial-transit unial-transit	er	aminer	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c.	1.7	ent Facti least Dis	ease		,		Interval Between Onset and Death	
I Records, P.O. Box 687  The law requires that the death certificat the has been signed by the attending phy page 2 should be detached for use as the	2 1	Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ∐ Yes 2 N No 9 ∭ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant at 9  Unknown	2 Fetal death	3  Ectopic pregna 5 Other (specify)		·		ate of delive	ery Day Year	
ds, P.( ires that the signed by the detail	3	ò	Part II. Other significant conditions continuing to death but not resulting in the underlying cause given in Part I.							tobacco use contribute to the cause of death?  Yes 2  No 3 □ Probably 4 □ Unknown		
II Records, P The law requires that ate has been signed b	page 2 short	Completed						24a. Wa au pe 1 Ves	topsy rformed?	. Were auto prior to co death?	ppsy findings available ompletion of cause of	
f Vital ysician; The s certificate director, pa		lo Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	ent 2 - ER/Outp	atient 3 DOA	ther:	of Death <i>(Check only</i> sing Home 5 $\square$ Re		her (Specify	у)	
Ivision of Vita Attending Physician: A death.  Sector: After this certifies by the funeral director.			27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Inju (Month, Day	ry 28b. Tir / Year) Inj	ury   W	jury at /ork? □ Yes 2 □ N		e how injury occu	rred		
Division of Vital or Attending Physician; T after death. Director: After this certificate thin by the funeral director, or		Certification:	3 Suicide 6 Could no 4 Homicide determin			, street, factory, offic	е		o (Street and Num Town, State)	ber or Rura	al Route Number,	
Division of Vital Re To the Hospital or Attending Physician. The I within 24 hours after death. To the Funeral Director, After this certificate ha completely filled in by the funeral director page	Total line	edical C		Physician: To the best of ixaminer: On the basis of end manner st	f examination and/							
To the		Me	29b. Signature and title of certifier	06 200			nse number	00	29d. Date signe	ed (Month,	Day, Year)	
Alleri		+	30. Name and address of person v						Inlife St Pr	altimo	re, MD, 21287	
SH-1 Rec	Stat gistra	~	31. Date filed (Month, Day, Year)  JUL 19		ar's Signature	hade		OO NOITH W	one ot, be	ardinoi	o, mo, 21207	

DHMH 17 Rev 1/2001

P.O. Box 68760, Division of Vital Records,

attending physicien and for use as the burial-transit The law requires that the death certificate be executed certificate has been signed by the rector, page 2 should be deteched funeral director. After this s effer dec. rai Director: All filled in by ō within 24 hours e To the Funeral I ro the Hospital

28a-f ehov

r than "netural", or iteme 23a or 28a-f ehov the Medical Examiner must be notified at

within 72 hours after

d 2 should be filed within 7 th and Mental Hygiene. 7 ie markad othar than "r

Saltimore, Maryland 21215-0036

Somo

State Registrar

Medical

29b. Signature and title of certifier

4 Homicide

29a. Certifier

120

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Physician/ 1 Day NEDRA KAY FLESHER Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) April 22,1945 6. Sex 7. Age (In yrs. last birthday) Funeral Days 1 M 2 T F 236-68-8101 65 Director Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c. City, Town or Location Director Examiner must be notified Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11325 YoungstounDrive items 23a 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. "natural", or Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed XX Divorced Year or Dates perfult. Page 1 and 2 should be filed within 72 hour. Des artment of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Ő administration 12 mortgage company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mabel Petersen Clarence C. Nuce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Fantacci - nephew 6622 High Beach Court East, New Market, Md. 21774 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Hagerstown Crematory 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 22. Name and Address of FacilitMinnich Funeral Home 21. Signature of Funeral Service Lice Value B 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Examin law requires that the death certificate be executed burial-transit Due to (or as a consequence of) attending physician Physician/Medical Box 68760 the IF FEMALE for use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 1 Yes 2 No ate has been signed by the page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 24a, Was an autopsy performed? Yes 2 No certificate Yes the Hospital or Attending Physician: hin 24 hours after death. Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, Hospital: Other: 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at injury work? 1 Natural 5 Pending 2 No 2 Accident 3 Suicide 4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2010

1:00 A M

9. Birthplace (State or Foreign

West Virginia

10d. Inside City Limits

Onset and Death

1 Yes 2 XXIo

3H-12

State Registrar

completed filled in by

Medical

29a. Certifier

only one)

29b. Signature and title of certifier

24 hours

within 2 To the I

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 1 - For State Registrar 23697 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death iee Physician/ aymona (-garner 19:40 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death MOSP , TAY MARY Leonardtown 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Hours 69 Director 216-40-2985 Maryland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits with the Maryland Director 1 Yes 2 X No |Maryland| St. Mary's California 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 23438 Aster Way 20619 United States 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If item 27 is marked others any injury or others. 1 Never Married 2 X Married 1 Yes 2 XNo Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Coilege (1-4 or 5+) Logistics Manager Defense Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Garner Evelyn Pettingill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Garner/Wife 23438 Aster Way, California, MD 20619 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cem 07/23/2010 | Cheltenham, Maryland 21. Signature of Fine and Address of Facility Brinsfield Funeral Hor Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Revol Metan tatic CAYCINUMAI Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Lungs Examiner Metastatic Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): Failure Respiratory Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director. After this certificate has been signed by the attending physician and reled filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last prieumania Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Year Day Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence \(6 \sum \) Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical To the Hosp within 24 hou To the Funer completed fill 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) Nerre Doo 6 8667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Meratee, M.D.

31. Date filed (Month, Day, Year) **JUL 20 2010** 

Registrar's Signature

25500 Point Lookout Road, Leonardtown,

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2010 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SQ₁p 5:13 рм Ora Lee Glover Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Camp Springs 5906 John Adams Drive Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 KF Months Days Hours (Month, Day Ye 94 **Director** <u>579-26-8281</u> Usual Residence of Decedent 28a-f shov "natural", or items 23a or 28a-f sho 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Prince Georges 1 XYes 2 No Camp Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5906 John Adams Drive 20748 AZU Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Ş 1 Never Married 2 Married 1 ☐ Yes 2 🗙 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐XNo Specify: Specify: Completed 3 ₩Widowed 4 Divorced Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ျှ Edward Barnes Lannie Harps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5906 John Adams Drive, Camp Springs, MD 20748 <u>Donna Gaston/daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State Donation 5 Other (Specify) Cedar Hill Cemetery 07-12-2010 Suitland, MD 22. Name and Address of Facility Strickland Funeral Services 21. Signatary 20748 6500 Allentown Rd., Camp Springs, MD Let 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Lung Cancer disease or condition resulting in death) weeks Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Litter order linjury Examine Due to (or as a consequence of) physician and s the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Kidney Disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Dementia 24a, Was an autopsy performed <u>Hvpertension</u> 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5  $\square$  Pending work? 1 ☐ Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I of Vital Division

P.O.

State Registrar

DHMH 17 Rev 7/2009

PP5EE00

DO 3720 Upton St., NW Washington DC 20016

07-08-2010

m Jullams Do

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

<u>Cynthia M. Williams</u>,

1 5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23699 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month July Physician/ 10, 2:20 P M 2010 Gerald James Gervino Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Riderwood Silver Spring I If Under 24 Montgomery 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Hours (Month, Day, Year) 2708/1942 North Dakota 67 **Director** 502-42-6604 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery 1 X Yes 2 No Chevy Chase 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 8101 S A Connecticut Ave #C505 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 X Married 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Federal Deposit life DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Insurance Corporation Attornev Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anthony Gevino Henrietta Mortensen permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Gervino / Spouse 8101 Connecticut Ave. #C505 Chevy Chase, MD 20815 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/15/2010 National Falls Church, Va. Crematory Signature of Funeral Service Licen 22. Name and Address of Facility Joseph Gawler's Sons 5130 Wisconsin Ave N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ Parkinson's Disease disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Bipolar Disorder 2 should 24a. Was an Were autopsy findings available prior to completion of cause of Hypertension certificate has autopsy page performed? death? ☐ Yes 2 ☐ No Chronic Lymphocytic Leukemia 1 ☐ Yes 2 🔀 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🕱 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work 1 Yes 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

20

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3110

Registrar's Sig

D44156

29d. Date signed (Month, Day, Year)

2010

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jacqueline July Pay. Gery 2010 6:00 РΜ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Hours Dec. 29, 1934 75 Pennsylvania Director 193-26-6314 Usual Residence of Decedent shov 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 X Yes 2 □ No East Greenville Borough Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18041 United States 261 Main Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working iife. DO NOT use retired)

Registered Nurse (Specify only highest grade completed) 2121 id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Healthcare Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Esther Moore John L. Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert C. Gery (Husband) 261 Main Street East Greenville, PA 18041 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Goshenhoppen Cem. 20a, Method of Disposition 20c. Location - City or Town, State Date 19, 1 X Burial 2 Cremation 3 Removal from State East Greenville, PA 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** PERFORATED VISCUS 18 HOURS Sequentially list conditions, Due to (or as a consequence or): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed MALNUTRITION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ISCHEMIC COLITIS THREE WEEKS AFTER COLECTOMY autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, page COLOSTOMY 1 ☐ Yes 2 ☑ No Yes 2 N 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

State Registrar

29a. Certifier

only one)

29b. Signature and title of certifier

A

31. Date filed (Month, Day, Year) **JUL 15** 2010

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32 Registrar's Signat

BRODSKY

COHPS

20io

ACQUELINE

9715

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MD 63623

29d. Date signed (Month, Day, Year) 7/14/10

ROCKVILLE

# 233

29c. License number

MEDICAL CENTER DR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 23701

		-	For State		State of Ivia	ai yiai iu		tificate			Torriditiy	Reg. N				
			Registrar  1. Decedent's Name	e (First, Middle, Las	t)						2. Date of De	ath			3. Time of Deat	ith
	Physicia		Myra Co	hen Gold	berg						July 7	, 2	010	ear	3:10 P	М
- 4	Medi Examir		4a. Facility Name (if					4b. City,	Town, or	Location of Death		4	c. County of I	Death		
			Suburba	an Hospit	al			_	thesd				ontgom			
	Funeral		<ol><li>Social Security No</li></ol>		7. Age	e (In yrs. las		If Under	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Yea <u>r</u> )		Coun	place (State or For try)	-
	Director		201-14-0	0788		84_	Yrs.				07/28/	192	5   P	enn	śylvania	1
	d now	ا ـِ ا	Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or Loc	cation						1	0d. Inside City Lir	mits
	ırylan a-f sh	양	MD	Montgom	ery	Chev	y Cha	se							1 🔀 Yes 2 🗆	□No
	or 28% notif	Pig	10e. Street and Nur					10f. Zip	o Code			10g. C	Citizen of Wha	t Cour	itry?	
	vith th	Funeral Director	3410 Bra	adley Lan	e			20	0815			Uni	ted St	ate	S	
	ems	ığ.	11. Marital Status	<u>-</u>	12. Was Decedent E	ver in U.S.	13. \	Vas Dece	dent of His	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No-		14. Race - American Indian,			
ď	ter de mine	by F	1  Never Marri	ied 2 🗌 Married	Armed Forces? 1 ☐ Yes 2 <b>X</b> If Yes, Give	No		Yes			Black, White, etc.					
Š	urs af ural"	ted	3 Widowed		Year or Dates.						wnite					-
L	2 hou	ed l	(Spe	15. Decedent's E ecify only highest gra	ade completed)		16a. Deced (Give	lent's Usu kind of wo O NOT use	rk done d	ation Juring most of work	ing	16b.	Kind of Busin	iess Ind	dustry	- 1
ç	thin 7	Completed	Elementary/Seco	onday (0-12)	College (1-4 or 5	i+)		ptio1	,				lerica	1		
7	Hygik Hygik Sther	Be (	17. Father's Name (	First, Middle, Last)			nece	peac.		18. Mother's Nam	e (First, Middle			*		
2	be fill ental ked c ev	မ	Harry M.	Cohen						Pearl M	orrison	n				
Š	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Merital Hygiene.  if health and Merital Hygiene.  item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at			ame/Relationship (T			19b. Mailir	ng Addres	s (Street a	and Number or Run	al Route Numb	er, City	or Town, Stat	e, Zip (	Code)	
Ž	12 stallth a alth a 27 is		Jeffrey	Goldberg	/ Son		3410	Bra	dley _	Lane Che	vy Chas	se,	MD 208	15		
0	of He of He rothe		20a. Method of Disp	position	Removal from State		ace of Dispo	sition (Name	me of other plac	e) 7/12/	Date	1	Location - Ci	•		
5	Page nent		1 ☐ Burial 22 4 ☐ Donation	The street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of t	y)	Nati	onal	Crem	atory	7 1/12/			11s Ch			
1 < / 0	permit. Page 1 a Department of H Important: If ite any injury or ott		21. Signature of Fu	neral Service Licens	see /					ss of Facility Jos Onsin Ave						
0	1 80 E # 9	at 2	300	ing con,	T		- 83									
0			shock, or hea	rt failure. List only c	plications that caused ne cause on each line	d the death. e.	Do not ente	er the mod	de of dylne	g, such as cardiac	or respiratory a	rrest,			Approximate Interval Between Onset and Deat	
7	Pnysician/		Immediate Cause (Final disease or condition resulting in death)  a. Myocardial Infarction Due to (or as a consequence of):													
1	Medical Examiner		resulting in death)	ſ	Due to (or as Atheros			eart	Dise	ease						
7			Eaquentially list of	anditions, at	Due to (or as			- Cur C								
	nsit	] <u>Ē</u>	if any, leading to in cause. Enter Unde Cause (Disease or	iinjury	Lung Ca		,									
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ç	cate be executed physician an transit sthe burial-transit	edical Examiner			Dementi	La 				<u>.</u>				_		
02/60	ificate ng phy as th		IF FEMALE;													
ĕ	r use	an/	23b. Was decedent in the past 12		23c. If yes, outcome 1 Live Birth	2 - Fetal	death 3	Ectopic		су			23d. Date Month		rery Day Year	
Č	death he ath	Physician/N	1 Yes 2	X No	4 Pregnant a	at time of de	eath 5 L	Other (s	specify)							
	requires that the death certific requires that the death certific been signed by the attending I should be detached for use as				ontributing to death b	out not resu	Ilting in the (	underlying	cause giv	ven in Part I.	23e. Did	tobacc	o use contrib	ute to t	he cause of death	h?
2	es th	a p	_								1 🗆	Yes	2 😾 No 3	☐ Pro	bably 4 🗆 Unk	known
7	requir	etec									24a. Wa	s an			ppsy findings avai	
8	e law has by	Completed	autopsy pric performed?									ath?	ompletion of caus	e of		
	n: The ficate		25. Was case refer	red to medical					26. PI	ace of Death (Chec	1 🗌 Yes	24	No 1 L	_ Yes	2  No	
2	sicial sicial certi	To Be	examiner?		Hospital:	ient 2 🗍 I	ER/Outpatie	nt 3 🗆 🗆	Oth			sidence	6 Other	(Specif	y)	
100	g Phy g Phy er this eral c		27. Manner of Deat		28a. Date of inju	iry	28b. Time o		28c. Injur	y at	28d. Describe					
O	ath. r: Aft	ical	1 X Natural 2 Accident	5 Pending Investigation	n	ly, rour,	,,	М		Yes 2 No						
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2	Hospita 24 hours Funeral eted filled	Medical	(Check	O Modern Ever	vsician: To the best of niner: On the basis of o	evermination	and/or inves	stigation in	n my opini	on, death occurred:	at the time, date	and pla	ace, and due t	o tne ca	ause(s) and manne	er stated.
کے	the hin the	ž	29b. Signature and		ea Practionar: To the	best of my	Ricwilledge,		c. Licens		ace, and due to		Date signed (			
	2 5	)	)	1	1100	2			D536			Jı	ıly 7,	20	10	
•	50		30. Name and add	ress of person who	completed cause of	death (Item	23a) (Type,	Print)								
			Ajay Re	ddy MD 32	00 Tower	Oaks :	Blvd.	Rock	vill	e, MD 208	352					
	St	ate	31. Date filed (Mon	th, Day, Vear	32. Registr	rar's Signat	ure form	del.								

State
Registrar

DHMH 17 Rev 7/2009

, Anna

polis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

31. Date filed (Month, Day, Year)

Parkway

069566

19/2010

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend Item 6 per FH G906 8/9/10 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar 23703 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year IC Physician/ 240 PM Alden 11 D. Haye Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Sa lisburl At piCL If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 05-22-1932 Pennsylvania 1 **№**M 2 □ F Months Hours Min. 221-20-0429 78 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f Worcester 1 X Yes 2 No MD Eden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral 1812 Old Furnace Road 21822 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?
1 ★ Yes 2 □ No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: 3 Widowed 4 Divorced Year or Dates. Korean White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 none Owner/operator Brake & Equipment Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Donald J. Have Mary Lea Carl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Haye/Wife 1812 Old Furnace Road, Eden, MD 21822 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Olivet Cristian Cem. 07/16/2010 4 ☐ Donation 5 ☐ Other (Specify) Eden, Maryland ignature of Fungar Service Licensee 22 Name and Address of Facility Hinman Funeral Home 11673 Somerset Ave., M00295 Princess Anne, MD 21853 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIONYOPATH /hysician/ disease or condition resulting in death) -Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate

Cause (Disease or iinjury Due to (or as a consequence of) within 24 hours a er death.

To the Funeral Drector: Af er this certificate has been signed by the attending physician and completed filled in by the fureral director, page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death 1 Yes 2 No 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Per Other (Specify) Hospica မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21802 SAUS BUR Cituran 130 733 WAS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 0 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 10:45 PM 2010 ames Haulseu 07 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University

5. Social Security Number Maryland Meclical Baltimore ob Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) 12-12-1944 Director Ь5 232-70-5245 Usual Residence of Decedent "natural", or items 23a or 28a-f show It from the street from the street at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No Brandywine MD Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7516 Earnshaw Dr. 50773 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 
If Yes, Give Black. White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Black Completed Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur ury or other traumatic event, the Me Iteal. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 2 should be filed w...
Alth and Mental Hygiene.
The marked other than "n".
The Me. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Director</u> of Facilities Federal Government 75 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Lucy Ann Dennis Nelson Haulsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7516 Earnshaw Dr., Brandywine, MD 20613 Celestine S. Haulsey / wife Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify MD Veterans Cemetery 07-13-2010 Cheltenham, MD 21. Signat re of Funers S rvice Liger 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd - Camp Springs - MD 20748 f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Fart T. Enter the disease, or complications that sales shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician Due to (or as a consequence of) myeloma disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months? Month Year 5 Other (specify) 1 Yes 2 g Unknown page 2 should be detached Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 Yes 2 No Yes 2 completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 2 XNo 1 M Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work? 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) and title of sertifier 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) MID 2010 1043445976 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimere mD 2120 tleanor MD 22 5. Greene 51. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 5 2010

DHMH 17 Rev 7/2009

Registrar

1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 9^{Day} 2010 ear 9:40 Рм Hamilton, Sr. Willie Charles Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Davs Min. Months Hours 2-(Nonth 1944 Year) Washington, DC 579-52-9564 66 Director Usual Residence of Decedent 28a-f show 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a. State Examiner must be notified at Director 1 1 Yes 2 □ No Washington DC 10e. Street and Number Apt 218 10f. Zip Code 10g. Citizen of What Country? 5 23a 20032 United States 4359 Martin Luther King Ave SW or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 x No Specify: Specify: Black "natural", 3 Widowed 4 X Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Should be filed within 72 I hand Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Federal Govn't Maintenance Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ဂ Jennie Walden Leonard Hamilton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4359 Martin Luther King Ave SW Apt 32²¹⁸
Washington, DC 20032 19a. Informant's Name/Relationship (Type, Print) Willie C. Hamilton, Jr. (son) 1 and 2 s of Health item 27 20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Crematory 7-20-2010 Brentwood, MD 20c. Location - City or Town, State 20a Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Dicersee 3401 Bladensburg Road Brentwood, MD 20722 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause Final Physician neumonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine The to forms a consection of all the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 as IF FEMALE: nse 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year jo ed by the a detached f Unknown P.O. cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4, ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Hospital Other: 1 🗆 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28b. Time of 28c. Injury at 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: s after death. I Director: After t Hospital or Attending Natural
Accident
Suicide
Homicide iniury 5 Pending M 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a. Certifier 1-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 68049 7/11 coma 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Sharma

Seem G S 31. Date filed (Month, Day, Year) 7600 Carroll Ave

Takoma

20912

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-	For State	State o	of Marylan		artment <i>tificate</i>					010	237	06
		Registrar  1. Decedent's Name (First, Middle	Last)	· .	061	incate	OI Death		2. Date of Dea	Reg. No.		3. Time of	
Physicia Medic		Charles Alfred	•						July	18ay	2010	3:45	Рм
Examin	er	4a. Facility Name (if not Institution, 13541 Paradise		nber)		-	wn, or Locati CS <b>tOWN</b>				ounty of Death hingtor	n Count	tν
Funeral		5. Social Security Number	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. la		If Under 1		der 24 Hrs.	8. Date of Birt	h	9. Birtho	lace (State of	
Director		006-16-2171  Usual Residence of Decedent	X	88	Yrs.				Sep. 2	5,1921	. Mai	lhe	
yland -f shov ed at	ctor	10a. State 10b. County			y, Town or Lo						1	0d. Inside Cit	
he Mar or 28a notifi	Funeral Director	Maryland Washir  10e. Street and Number	igton Cour	nty  Hag	gersto	<b>√</b> ∏ 10f. Zip C	ode			10g. Citizer	n of What Cour		2 jaj 110
with t	eral	13541 Paradise	Dr.			217	42				U.S.A.	·	
death items	Fun	11. Marital Status	Armed Fo	edent Ever in U.S rces?		Was Deceden f Yes, specify	t of Hispanic Cuban, Mex	Origin? (Spe ican, Puerto	cify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	1 $\square$ Never Married 2 $\square$ Marr 3 $X$ Widowed 4 $\square$ Divorced	ied 1 X Yes If Yes, Giv Year or Dr	e 1942- ates:1945		I∐Yes 2	X No Spec	cify:		Spi	· · · · · · · · · · · · · · · · · · ·	nite	
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DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 10 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day July 18 2010 M 1930 Ε. Yvonne James Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Prince Georges Southern Maryland Hospital Clinton If Und Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🔀 F Months Davs Hours Min (Month, Day, Director 577-56-1488 66 1943 Dec Wash Usual Residence of Decedent show 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 XYes 2 No Hills MD PG Temple 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3420 Rickey Avenue #245 20748 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black 3 ☐ Widowed 4 🔀 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Border Patrol 12 <u>Administrator</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important. If item 27 is marked o any injury or other traumatic eve and Mental F is marked o ည William S. Proctor Pauline Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10004 Edgewater Terrace Fort Washington, Md. 20 <u>Donna Savage/daughter</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 7/27/10 cemetery, crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Riverdale Park Crematory Riverdale, 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ACTEREMIA disease or condition Medical resulting in death) Examiner ROSEPSIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit DIABETES. To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events NCONTROLLAD Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rs after death.

al Director: After this certificate ha perform 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be 1 🗆 Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending wark 1 🔲 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. TUCT

DHMH 17 Rev 7/2009

State Registrar and address of person who completed

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ise of death (Item 23a) (Type, Print)

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-32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2010 Physician/ JULY 3, 9:45 PM GRAHAM L. JACKSON Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE"S 2730 LORRING DRIVE # 103 DISTRICT HEIGHTS 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** Days Hours 1**X** M 2 □ F 1 17 12 7 1 930 Washington, 79 Director 579-36-1943 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at Director 1 X Yes 2 □ No Maryland Prince George's District Heights 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20747 United States 2730 Lorringd Drive # 103 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11 Marital Status Armed Forces?
1 XYes 2 □ No Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 1 ☐ Yes 2X No Specify If Yes, Give Specify: Black 3 ♥ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Military 11 Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H permit. Page 1 and 2 should be filk Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve Walter Louis Jackson Mary Leaver H. Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7325 Cross Street Forestville, Maryland 20747 Belinda Ingraham / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/14/2010 Suitland, Maryland Cedar Hill 21. Signature of Funeral Service License 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike forestville, Maryland 20747 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure Immediate Cause (Final Physician/ Chronic disease or condition Medical resulting in death) Examiner cancer of Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Obstraction 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was a ... autopsy performed? cate has t 1 Tes 2 No the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor **To the Fune** completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 07-12-2010 D 51520 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Old Marlboro Pike Upper Marlboro, Md 2000 pisholad 74314 Bahram 31. Date filed (Month, Day, Year) State 1 5 2010

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Physician/ July 11, Rena Jacobson 6:35 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Potomac Valley Nursing Home Montgomery Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Funeral 1 M 2 XF Months Days Hours Min. 02/28/1925 Poland 85 **Director** 052-48-4417 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No Maryland Montgomery Silver Spring 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 15115 Interlachen Drive 20906 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. δ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: White Specify: "natural", Completed 3 X Widowed 4 ☐ Divorced Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be flik ment of Health and Mental tant: If item 27 is marked o ပ္ Leon Potok Hanna Salinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Cifarelli, daughter 717 Owens Street, Rockville, Maryland item 2 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or of XBurial 2 Cremation 3 X Removal from State Beth Moses Cemetery 07/13/2010 Long Island, NY 4 ☐ Donation 5 ☐ Other (Specify) . Si nature di neral Se vic. Licensee 22 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. MO1255 1091 Rocvkille Pike, Rockville, 20852 23a. Part : Enter the Viseaser or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pancreatic Cancer Vear Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or sels consequence of) physician and s the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Year 5 Other (specify) Month Pregnant at time of death g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed' 2 🗆 No Yes 2 **X**No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes 2 X No Other: ျ 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D38262 July 12, 2010 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

. Registrar's Signature

2401

Research Blvd, Rockville, Maryland 20850

Dr. Anurit Mendhiratta, Suite 330,

15 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jason D2010 Lawrence  $J_{\mathbf{u}}^{\text{Month}}$  12, 2:20 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery 3330 N. Leisure World Blvd., #417 Silver Spring If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 | F Hours 11/2671932 112-24-5506 New York Director 77 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Maryland Director Montgomery MD Silver Spring 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States by Funeral 20906 3330 N. Leisure World Blvd., #417 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc.
White 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than 1 and 2 should be filed within in Health and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Pharmacist Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Anne Hellman Theodore Jason traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3330 N. Leisure World  $^{\rm B}_{\rm Spring}$ ,  $^{\rm H4}_{\rm IMD}$  20906 Carole R. Jason-Wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem Gdns 7/14/2010 Olney, Maryland 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville, MD 20852 of Funeral Service Licensee MO1255 23a. Part 1. Enur the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 19 Years Physician/ Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Coronary Artery Disease 19 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 L 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Fibrillation 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Were autopsy findings available prior to completion of cause of Diabetes Mellitus 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No Yes 2X No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 🖺 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 29b. Signature and file of certifie 29d. Date signed (Month, Day, Year) July 13, 2010 D42777 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Weinstein, MD 18109 Prince Philip Drive Olney, MD 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 15 2010

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 13^{Day} 07^{Month} **Physician** 2:50 2010 A M HOWARD W. KEMP /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** TALBOT TALBOT HOSPICE HOUSE EASTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Months 1**X** M 2□ F 03/15/1945 65 DE 218-40-5690 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State ns 23a or 28a-f show must be notified at 1 X Yes 2 □ No Director **EASTON** MD TALBOT 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number UNITED STATES 21601 305 CHOPTANK AVE. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, "natural", or items 11. Marital Status Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify Specify: WHITE 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DELIVERY DRIVER TRANSPORTATION undly be filed after and Mental Hygis marked other th. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NORA MAE WILSON HOWARD KEMP ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once. MARGARET KEMP/WIFE 305 CHOPTANK AVE., EASTON, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State SPRING HILL CEMETERY 07/16/2010 EASTON, MD 4 ☐ Donation 5 ☐ Other (Specify) ure of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final CANCER Physician UNG. YEAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of) Box 68760. physician Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 □ Yes 2 □ No 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for Ö 9 Unknown 9 Unknown ٦. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autop performe 2 2 certificate ha 1 ☐Yes 2 ☐No 1 ☐ Yes 26. Place of Death (Check only one director, 25. Was case referred to medical Be examiner' Other: 4 \(\to\) Nursing Home \(5 \) Residence \(6\)X\(\text{Other (Specify)}\) HOSPICE 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After th funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death or Attending Natural Accident Natural 5 Pending investigation within 24 hours after vc...
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number title of certifier 29b. Signature D39887 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8221 TEAL DRIVE, SUITE 301, EASTON, MD 21601 12 DAVID H. SMITH, MD 31. Date filed (Mosth E State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Andrew Sorie Kanu July 2010 6:45 A. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7030 Palamar Terrace Lanham **Prince Georges** Social Security Number g. Birthplace (State or Foreign Country West Africa Sierra Leone, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea **December** Sex 1 M 2 I 7. Age (In vrs. last birthday) 1951 **Funeral** Hours 58 Director 225-61-3849 Usual Residence of Decedent 28a-f shov 10a. State 10b Counts 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Lanham Prince Georges Maryland 1 X Yes 2 No 10e. Street and Number 6 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 7030 Palamar Terrace 20706 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ **Black** 1 ☐ Yes 2 X No Specify. should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", 3 Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Caregiver Rock Creek Foundation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Santigie Mariama Kanu Kanu permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any Injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josephine Albertie Wells-Kanu 7030 Palamar Terrace; Lanham, Maryland 20706 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) July XBurial 2 Cremation 3 Removal from State 4 Denation 5 Other (Specify) Silver Spring, Maryland Gate of Heaven Cemetery Ignature of Funeral Service 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Immediate Cause (Final 18 months Physician Metastatic Colon Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): death certificate be executed Cause (Disease or iinjury physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending p yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death signed by the a g  $\square$ Unknown g 🗌 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy page performed? Yes 2 No Hospital or Attending Physician: The 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗶 No Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending injury neral Director: Af dilled in by the fu 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) To the Hospital of within 24 hours a To the Funeral D completed filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled i Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) July 1 13, 2010 D33224 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1400 Forest Glen Road; Suite 435 Ram S. Trehan, M.D. Silver Spring, Maryland 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 July 12, Physician/ 7:50 p M Edward V. Kiley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 3144 Gracefield Rd., Apt. GV 105 Silver Spring Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) ec. 28, 1917 1**X**□ M 2 □ F Months Days Hours Director 577-05-5039 92 Dec. D.C. Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 ☐ Yes 2 No Prince George's MD Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 USA 3144 Gracefield Road, Apt. GV 105 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

Y Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 XWidowed 4 Divorced WWII White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) l Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Senior Vice President Trucking Industry of Health and Mental Hygier of Health and Mental Hygier If item 27 is marked other in other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John N. Kiley Dora Nolan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Megan L. Brewer/Daughter 77 Inkberry Circle, Gaithersburg, MD 20877 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot July 2010 1 K Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery Silver Spring, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W,. Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Liver Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): ng physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury Metastasis to Bone that initiated events resulting in death) Last Due to (or as a consequence of attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 9 Unknown the should be detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: Other: 1 Tes 2 **X**No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after death. Certificate: work? injury 1 X Natural 5 Pending M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined building, etc. (Specify) 24 hours a Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 L 3 L Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D59524 July 13, 2010 B+1 Queen ruthumani MD

State Registrar

Loveen Puthumana, MD

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31. Date filed (Month, Day, Year

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Loveen Puthumana, MD 3110 Gracefield Road, Silver Spring, MD 20904

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>010</u>  $J_{u1y}^{\text{Month}}$ Year Physician/ Harry Kranz 1:27 а Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Riderwood Village Assisted Living Silver Spring Montgomery Social Security Number If Under 1 Year If Under 2 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 ★ M 2 □ F Days Hours Min New York 86 Director 145-18-7682 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3128 Gracefield Road #311 20904 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White Specify: Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working Page 1 and 2 should be filed within 72 ment of Health and Mental Hyglene. ant: If item 27 is marked other than ' life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) <u>Journalist</u> US Government Manager other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Abraham Louis Kranz Anna Zimmerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharlene Kranz, daughter 3114 Wisconsin Ave, NW, #403, Washington, DC 20016 20b. Place of Disposition (Name of cemetery, crematory or other place)

Ling Memorial Gdns 07/14/2010 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC. M01255 1091 Rockville Pike, Rockville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Coronary Artery Disease vears Medical Due to (or as a consequence of) Examiner Ischemic Cardiomyopathy 4 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 5 Other (specify) been signed by the a should be detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed' 2 🗌 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: ASSISTED 4 Nursing Home 5 Residence 6X Other (Specify) Living 1 Yes 2 😿 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the fun Natural 5 Pending Division 1 🗌 Yes 2 🗌 No Investigation Could not be ☐ Accident ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature an 29d. Date signed (Month, Day, Year) D24093 July 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Mark Parkhurst, MD,

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31. Date filed (Month, Day, Year)

Box 68760

P.O.

of Vital

22. Registrar's Signature

3110 Gracefield Rd, Silver Spring, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Bepartine of Health and Mental Hygiene Per inf 8906 8-17-10 Vt Certificate of Death For State Registrar amend item 17 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month JUL 2010 12 7:10 A HENRY APAWAN KWAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Sex 8. Date of Birth Days Hours (Month, Day, Year, July 08, 1 1 🛛 M 2 🗆 Months 92 Director 586-60-6797 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Montgomery Rockville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11703 Hunters Lane 20852 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 No 1941— 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Divorced 1961 Filipino . Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Major Military Be 17. Father's Name (*First, Middle, Last)* **Apolinario** <del>Palinano</del> Kwan 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Francisca Francica Apawan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11703 Hunters Lane, Rockville, Maryland 20852 Nenita L. Kwan - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🔀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/26/2010 Arlington, Virginia Arlington Natl Cem. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. inn Kowe 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician. PULMONARY EDEMA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to for as a consequence of, sath cerum. ne attending physician and To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has a completed filled in by the funeral director, page 2.8 autopsy performe death? 2 No 2 X N Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖼 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 10+1 0101245334 (VA) NATIONAL NAVAL MEDICAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BETHESDA MD 20889-5600 GREGORY S. FUHRER MC USN 31. Date filed (Month, Day, Year, Registrar's Signature harred State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month CSS AM Albert Eugene Kretsinger TUIL 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 21915 Martin Circle Hagerstown Washington County If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number . Sex 1 X M 2 □ F 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8 Date of Birth Funeral May 20, 1925 217-28-4068 Maryland **Director** 85 Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 21915 Martin Circle 21742 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married <u>م</u> Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) Meat Cutter Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Kretsinger Iva McKinsey Kretsinger other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shu Department of Health an Important: If item 27 is any injury or other trau 21915 Martin Circle Hagerstown, MD 21742 Mary E. Kretsinger-wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Ringgold Cemetery 7-22-2010 Ringgold, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery FuneralHome 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the human transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Veal Pregnant at time of death Yes 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No 1 Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Muchael 4166 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cimius 41-20 nedical neck 31. Date filed (Month, Day, Year) 32 Registrar's Signatur State Registrar

		_ For	State of Ma	arylan	d / Depa	artment	of He	alth a	nd Me	ntal Hy	giene	0016			
		State Registrar		_	Ce	rtificate	of D	eath			Reg. No.	2010	) 2	237	17
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Funeral		5. Social Security Number 6. Sex	2 (2/1/	<u> </u>	ast birthday)	If Under 1		f Under 24	4 Hrs. 8	. Date of Birt (Month, Da	th	9. B	rthplace	State or Fo	oreign
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Marical Examination at once.	ŀ	21. Signature of Funeral Service License	)Pr // /			Name and A								<u> </u>	
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), a		Sate filed (Month, Day, Year)	JON 1 MD 32. Registra	r's Signa	rost i	Uttice	KC	1 2	nte	101 U	Jalo	ort, M	D	1060	12
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State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of M	ai yiai ic		tificate of E			Reg. N	7 H I H	23718
	Physicia	1/	1. Decedent's Name (First, Middl			· · · · · ·	W		2. Date of De Month July	eath 22	Day 2010	3. Time of Death
ent.	Medic Examin	al .	Nadine  4a. Facility Name (if not institution	r, give street and number)			Mixter  4b. City, Town, or	Location of Dea			Lc. County of Death	1854 P ^M
1	LAdillii	<b>3</b> 1	13156 Independ	dence Road			Clear S				Washingto	n
	Funeral Director		5. Social Security Number 184-12-0210	6. Sex 7. Ag	e (In yrs. las 88	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		av. Year	9. Birth 922 Penns	place (State or Foreign http:) sylvania
	ind ihow at	٦	Usual Residence of Decedent  10a. State 10b. County	у	10c. City,	, Town or Lo	cation					10d. Inside City Limits
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Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Ma</li><li>3 ☒ Widowed 4 ☐ Divorce</li></ul>	Armed Forces?  1  Yes 2		1	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 ሺ No		rto Rican, etc.)		Black, White,  Specify: White	etc.
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			For State Registrar		State o	of Maryla	and / Depa <i>Cer</i> a	rtment <i>tificate</i>			nd Me				0	2371	9
	Dhuelei		1. Decedent's Name (	(First, Middle, La	ast)						2	Date of De		ay Y	'ear	3. Time of Dea	ath
	Physici /Medic		IRVING F	REDERIC	K MORRI	S						July	12,	201		5:26	_₽
	Examin	er	4a. Facility Name (If r				_	4b. City, T	own, or L	_ocation of	Death			,			
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	pu ,		Usual Residence of D			100	City Taylor and an	ation					Reg. N. 2 0 1 0  Death Day Year 12, 2010  4c. County of Death Talbot Birth Pay, Year) 10g. Citizen of What Coun UNITED STATI No 14. Race - America Black, White, Ispecify: WH  16b. Kind of Business/Inc INSURANCE Cite, Maiden Surname) CON INSURANCE Cite, Maiden Surname) CON EASTON, MD  20c. Location - City or To EASTON, MD  23d. Date of delive Month  23d. Date of delive Month  23d. Date of delive Month  24b. Were autoprior to condeath? 25c. 2 No 3 Professor			d. Inside City L	imite
	shov	ō	10a. State 1	10b. County <b>TALBOT</b>		100.	City, Town or Loc								10	u. ⊪side ony L 1 <b>X</b> Yes 2[	
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	burs after death with the Marylan ral", or items 23a or 28a-f show Examber must be refiffed at		402 BRI		TTT				1601						4		
	death	Funeral	11. Marital Status	DOL DIK		edent Ever in			ent of His	panic Orig	in? (Speci	fy Yes or No		14. Race -	America	ın Indian,	
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alti	permit. Pages Department of Important: If i any Injury or once.		21. Signature Fund		1		PARK		Address							OME D	
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			23a. Part . Enter the	e disease, or or failure. List only	nplications that	caused the de	eath. Do not ente	r the mode	of dying	, such as	cardiac or i	respiratory	arrest,			Approximate Interval Between	en
	Physician		Immediate Cause (Fi	inal	_a NO	on s	MACC	CE	26	La	NC	CA	NC	ER		Onset and Dea	25
	/Medical Examiner		resulting in death)	•	Due to	(or as a cons	equence of):			na		4 0 -	100	. ~			
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	uted d ansit	Examiner	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in that initiated events	ying <b>1</b>		عرا	BEA	1	15	CENT.	v4				- 1	WED	24
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Вох	Physician: The law requires that the death certific this certificate has been signed by the attending I rail director, page 2 should be detached for use as	Physician/Me	23b. Was decedent p in the past 12 m	nonths?		birth 2 F	etal death 3 🗌	Ectopic pr								ry Day Yea	ır
Ö	the di y the iched	ysic	1 □Yes 2 □ 9 □ Unknown	No	9 □ Unk		or death 3 🗆	TOTHER (Spe	y)								
ر. ح.	s that ned b	by Pr	Part II. Other signific	ant conditions	contributing to o	leath but not i	resulting in the un	derlying ca	use giver	n in Part I.		23e. Did	tobacco	use contrib	oute to the	e cause of deat	th?
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of	Physical direction	은	1 ☐ Yes 2 🔼N 27. Manner of Death	lo	Hospital: 1  28a. Date		ER/Outpatient			4 Nui						′)	
O	nding Physician: th. : After this certifica ) funeral director, p	tion	1 Natural 2 Accident	5 Pending	(Moi	nth, Day, Year	) Injury	M Z	c. Injury Work? 1 □ Y	? ^{an} ′es 2. □ N		d. Describe	: riow iriju	ary occurred	1		
Division of Vital Records,	Atten r deat sctor: by the	Certification: To	3 Suicide	6 Could not		e of Injury - A	l t home, farm, stre ec <i>ify)</i>	et, factory,				f. Location	(Street a	and Number	or Rura	Route Number	r,
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	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	one) 29b. Signature and tit	tle of certifier	and mar	nner stated.		29c.	License	number			29d. D	ate signed	(Month, L	Day, Year)	
	,- > F 0		100	202	C. P			6	213	337	36		JU	uy	( =	201	10
			30. Name and a dires	ss of person who	completed cau	se of death (I	tem 23a) (Type, F	erint)			0					105	
4	2+VA	a d	Anyl	2001	n 10 n	10	Lala N.	1 -1		5/	25%	ctor	- 1	1071		1	
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Physician/

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10a. State

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**Funeral** 

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and Mental Hygiene.

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Certificate:

Medical

29b. Signature and title of certifie

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Tul 20 Valli Anita Matthews 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Doctor's Community Hospital Lanham 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🖫 F 9 - 2 4 - 1 Months Days Hours Min. 60 NY 126-38-3876 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits District Heights 1 X Yes 2 ☐ No Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20747 3005 Grant Oak Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Industry Social Worker 18. Mother's Name (First, Middle, Maiden Surname) Celestine A. Thigpen 17. Father's Name (First, Middle, Last) Walter A. Lucas, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 3005 Great Oak, Dr., District Heights, MD Rene' A. Matthews/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Cedar Hill Cem. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07 - 17 - 2010Suitland, MD 20746 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. Hedgman M01374 Cedar Hill FH,4111 PA Ave., Suitland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final EPSLS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy perform death? 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at 28d. Describe how injury occurred

attending physician and for use as the bunal-transit that the death certificate be executed Box 68760 detached Ö þ signed I Records, page 2 should To the Hospital or Attending Physician: The law I within 24 hours after death.

Of the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 s of Vital Division

1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENA AN EMIA 25. Was case referred to medical examiner? 27. Manner of Death 28a. Date of injury (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

29a. Certifier	1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, a	nd due to the cause(s) and manner as stated.
(Check	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a	
only one)	3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and pla	ce, and due to the cause(s) and manner as stated.

29c. License number 29d. Date signed (Month, Day, Year) 07-11-10

		_			_							
0.	Name	and	address of	person	yyYo	completed	cause	of death	(Item	23a)	(Type,	Prin
	- 10	1		-	No.	0.		1	.//		- 0	- 4

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ ZO Year Maabie 11:25 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clinton Prince Georges Futur<u>e Care Pineview</u> g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 M 2 X F Days Hours 10-29-1914 579-24-5937 95 Director Usual Residence of Deceden ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Prince Georges Temple Hills 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20748 26th ave. 3351 AZU 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Completed 3 XWidowed 4 ☐ Divorced Black Year or Dates. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mabel Holland Kenneth Lipscomb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Magbie / son 6704 Drylog St., Capitol Heights, MD 20743 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) injury o Memorial Cem. 17-14-2010 | Suitland, MD of Funeral Service Levin 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd -- Camp Springs - MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Quysician** neamonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease Or iinjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the ! use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Year 5 Other (specify) Month Pregnant at time of death should be detached 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ementa 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? topenia 24a, Was an Pancy has r page 2 autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Be examiner? Hospital Other: 2 × No ٩ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Natural injury 5 Pending Accident Investigation the Suicide 6 Could not be 3 

☐ Suiciae

4 

☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signatu title of de 29c. License number 29d. Date signed (Month, Day, Year) 10053337 2010

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

1 5 2010

Smith

Baltimore, Malzezaki

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ho completed cause of death (Item 28a) (Type, Print

2835

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:34 PM 2010 mort Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Howard County General Hospital Columbia <u>Howard</u> Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 **X**) M 2 □ F Months Hours Min. (Month, Day, Year) 09/15/1929 80 Yrs Director 117-26-1356 Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1X Yes 2 □ No Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2647 Buckingham Road permit. Page 1 and 2 should be filed within 72 hours after death. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items may injury or other traumatic event, the Medical Examiner muone. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes : Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. 3 Divorced 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Engineer</u> Aero Space Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Francis Rose Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Marsha Mittelman / Wife</u> 2647 Buckingham Rd. Ellicott City, MD 21043 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Grdns: 07/11/2010 Olney, MD 22 Name and Address of Eacility
Edward Sagel Funeral Direction Inc.
1091 Rockville Pike Rockville, MD 20852 21. Signature of Funeral Service Licenses MO1477 Blake 1091 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ inst. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? certificate 2 🕱 No Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner?
1 Yes 10 2 X No Other: □ Inpatient 2 K ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛮 Natural 5 Pending 1 Tes 2 No Accident
Suicide
Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Prectioner: To the best of my knowledge, de 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Donald

31. Date filed (Month, Day, Year

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32. Registrar's Signature

<u>5755 Cedar Lane Columbia, MD 21044</u>

			1 - State Registrar	Maryland / Depa <i>Cer</i>	artment of H tificate of D			giene Reg. No <b>2 ()</b>	In	23723
	Dhuniain	/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath		3. Time of Death
	Physicia Medic		Marshall Theodore		ers		July	16 20	Year 010	08-20 AM
	Examin	er	4a. Facility Name (if not institution, give street and number	)	4b. City, Town, or			4c. County of		
			11332 Eastwood Drive 5. Social Security Number   6. Sex   7. /	And the service that highly do a	Hagerst	OWN If Under 24 Hrs.	Lane (B)		ning	
ı	Funeral Director		215-20-7803 1 ¹ ✓ M 2 □ F	Age (In yrs. last birthday)  Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day May 10	v. Year)	9. Birthp Count (ary	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "hatural", or items 23a or 28a-f show amportant: If item 27 is marked other than "hatural", or items 25a or 28a-f show amportant: Item 27a is marked other traumatic event, the Medical Examiner must be notified at once.	tor	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation				1	0d. Inside City Limits
	Mary 28a-1 otifie	irec	Maryland Washington	Williamsp	ort					1 Yes 2 No
	h the	al D	10e. Street and Number		10f. Zip Code			10g. Citizen of W	nat Coun	itry?
	ms 2; must	ner	303 S. Conococheague St.	ie i uo Iao	21795			U.S.A.		
<b>'</b>	or itel	Completed by Funeral Director	11. Marital Status 12. Was Deceder Armed Forces 1 Never Married 2 Married 1 Ves 2	t Ever in U.S. 13. \	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	ecity Yes or No- Rican, etc.)		- Americ , White, e	an Indian, etc.
980	s afte ral", d Exan	q pe	3 Widowed 4 □ Divorced If Yes, Give Year or Dates	1 100	I ☐ Yes 2 🔼 No	Specify:		Specify:	Whit	- e
2-0	natur dical	olete	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ient's Usual Occupa kind of work done di	tion		16b. Kind of Bus		
21	nin 72 ne. han " e Mer	omp	Elementary/Seconday (0-12) College (1-4 c	114- 0	O NOT use retired)	-	ng			
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ano	ntal Fied of	TO B	17. Father's Name (First, Middle, Last)			18. Mother's Name		Maiden Surname)		
Ž	ould b		Morris Myers  19a. Informant's Name/Relationship (Type, Print)	405 14-11			nhart	O't T Ot	-1- 7:- (	2
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ē,	1 and f Hea item othel		20a. Method of Disposition	20b Place of Dispo	sition (Name of		Date	20c. Location - 0		
E O	age lent o nt: If ry or		1 Burial 2 Cremation 3 Removal from Sta 4 Donation 5 Other (Specify)	Rest Have	natory or other place	1	/2010	Hagersto		Marri and
Baltimore, Maryland 21215-0036	permit. F Departm Importa any inju once.		21. Si turo f Funeral Service Ligensee		. Name and Address	s of Facility Res	t Haven	Funeral	Cha	nel
8	e a m e		7 X. I							ryland 2174:
	hysician/	0.00	23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each I Immediate Cause (Final disease or condition	ed the death. Do not ente ne. S +a +i C C				est,		Approximate Interval Between Onset and Death
	Medical Examiner	ı	resulting in death)  Due to (or a	s a consequence of):						
		er	Sequentially list conditions, b.	s a consequence of):					_	
	ed nsit	min	if any, leading to immediate Due to (or a cause. Emer Underlying Cause (Disease or iinjury	s a consequence oi):					- 4	
	icate be executed I physician and s the burial-transit	Examiner	that initiated events c.	s a consequence of):					+	
0	be e	edical	d.							
8760	ificate ig phy as the	Med	IE EEMALE.							
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  Within 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as it	Physician/M		n 2 🗌 Fetal death 3 🗆 at time of death 5 🗆	Ectopic pregnancy Other (specify)	′		23d, Date Mon		ery Day Year
s, P.O	v requires that th been signed by should be deta	Completed by Pł	Part II. Other significant conditions contributing to death Shortness of by		nderlying cause give	en in Part I.				ne cause of death?
ord	required shoul	lete	HYPERTENSIO.				24a. Was a	an 24b. W	ere autor	osy findings available
ec	The law cate has page 2 s	omp	REFLUX ESOPHA				autop perfor	rmed? de	eath?	mpletion of cause of
<u>e</u>	sician: The certificate l irector, page	Be C	25. Was case referred to medical	911 13	26. Pla	ce of Death (Check		2 No 1	∐ Yes	Daughters
Ë	Physici this cer ral direc	To B	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpa	atient 2 - ER/Outpatier	t 3 DOA Other	r: 4 🔲 Nursing Ho	me 5 🗆 Resid	ence 6 X Other	(Specify	Residence
oţ	ding Ph th. After th funeral		27. Manner of Death 28a. Date of in 1 Natural 5 Pending (Month, I		28c. Injury work?	at		ow injury occurred		
lon	tendii Jeath. Ior: A: the fu	ifice	2 Accident Investigation		M 1 🗆 Y	∕es 2 □ No	<u> </u>			
<u>Nis</u>	e Hospital or Attendin n 24 hours after death. e Funeral Director: Aft pleted filled in by the fun	Certificate:	4 Homicide determined 28e. Place of I	njury - At home, farm, stre etc. <i>(Specify)</i>	eet, factory, office		28f. Location (S City or Town	treet and Number n, State)	or Rural	Route Number,
	pital ours a eral [	cal	29a. Certifier 1 Certifying Physician: To the best	of my knowledge, death of	occured at the time	date and place an	d due to the car	ISO(s) and manner	as state	d
	the Hospital hin 24 hours a the Funeral I	Medical	(Check 2 Medical Examiner: On the basis or only one) 3 Certifying Nurse Practioner: To the	examination and/or invest	igation, in my opinior	n, death occurred at	the time, date ar	nd place, and due t	to the cau	use(s) and manner stated.
	To the I within 2 To the I compler	2	29b. Signature and title of certifier		29c. License			29d. Date signed		
			1 Kemah	MS	0050	8181		JULY	16	,2010
			30. Name and address of person who completed cause of		rint)				ĺ	
34	13+1			4 E. ANTI	TIETAM	ST. #	306	HAGERS	0001	y mb
	Stat Registra		31. Date filed (Month, Day, Year)  JUL 19 2010  32. Regis	trar's Signature	arted					

			For Amend Item 2	8f ^{State} of Mary	66,08	<b>P209/2010</b> 101 Certificate of	Health and Death	Mental Hy	/giene Reg. No. 201	0 23724
	Physicia		1. Decedent's Name (First, Middle, Li	ast)				2. Date of Do Month		3. Time of Death
	Medie Examir		4a. Facility Name (if not institution, give WASH, NG 70% Co	re street and number)		4b. City, Town	or Location of Dea		4c. County of D	
	Funeral	Г	Social Security Number     6.	Sex 7. Age (In	yrs. last bir	thday) If Under 1 Yea	ır If Under 24 Hr	8. Date of Bi	rth g.	Birthplace (State or Foreign
	Director		Usual Residence of Decedent			Yrs.		April	1,1920 Ma	ry Land
	//arylanc 8a-f sho tified at	Director	Maryland Washing		c. City, Tow lagers	n or Location Stown				10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	ith the N 3a or 2 t be no	al Di	10e. Street and Number 988 Mt. Aetna R			10f. Zip Code			10g. Citizen of What	Country?
	death w items 2 ner mus	Funeral	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S.	21742		Specify Yes or No-	1-1111000 711	nerican Indian,
9800	ge 1 and 2 should be filed within 72 hours after death with the Maryland tof Heath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates.		1  Yes 2X		to Hidan, etc.)	Black, Wi Specify: Wh	
21215-0036	ו 72 hou an "natu Medica	Completed	15. Decedent's (Specify only highest g	rade completed)	16a	Decedent's Usual Occ (Give kind of work done life. DO NOT use retire	e during most of wo	rking	16b. Kind of Busines	ss Industry
1212	d be filed within 7 Aental Hygiene. Irked other than tic event, the M	Be Co	Elementary/Seconday (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4 or 5+)	Pr	ocurement (	lerk		Air Craft	Mfg.
Maryland	ld be file Mental I arked o	2	John R. Williams						, Malden Surname) lling Will	iams
Mar	12 shoualth and 27 is m		19a. Informant's Name/Relationship ( Barbara A. Lease	,		er, City or Town, State, MD 21742	Zip Code)			
altimore,	ge 1 and it of Hea If item or othe		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 [	Removal from State	0b. Place o cemete	09 Woodland of Disposition (Name of try, crematory or other party)	ace)	Date	20c. Location - City	or Town, State
altim	permit. Page Department o Important: If any injury or once,		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Licer	ify)	Smith	sburg Crema			Smithsbur . Fiery Fu	g, Maryland Deral Home
B	P P E E		Kartlin Zay	aron Sut	en daeth Do r	1331 East	ern Blvd	North	Hagerstown	MD 21742
11	Physician/	N 1	shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.		y Ensolus		or respiratory ar	rest,	Approximate Interval Between Onset and Death
F	Medical Examiner		resulting in death)	Frackie	KIAT.					
	d His	niner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	b. Due to for as a con						
メ	cate be executed physician and the burial-transit	edical Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	C. Due to (or as a con-	sequence o	of):	0		MEDICAL EXAMINER	
	cate be physici s the bu			d			CERTIFICA	ON APPROVED BY	MEDI	
, X 687	th certifi ttending or use as	ian/M	F FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	Fetal death	n 3 ☐ Ectopic pregna			23d. Date of c	·
. B	the dea by the a ached fe	by Physician/M	1 Yes 2 No 9 Unknown	4  Pregnant at time 9  Unknown	of death	5 Other (specify)			Month	Day Year
90 Msh. C. Records, P.O. Bo	ires that signed d be del	d by F	Part II. Other significant conditions of	ontributing to death but not	t resulting is	n the underlying cause (	given in Part I.	1	obacco use contribute Yes 2 No 3	to the cause of death?
% Sord	aw requias been 2 shoul	Completed						24a. Was autor	an 24b. Were a	utopsy findings available ocompletion of cause of
R Re	an: The tificate h for, page	Be Con	25. Was case referred to medical			26.1	Place of Death (Che	perfo 1 ☐ Yes	rmed? death?	es 2 4 No
of Vital	Physicii this cer ral direc	ျှ	examiner? 1 X Yes 2 100	Hospital:  1 Inpatient 2  28a. Date of injury		tpatient 3 DOA Ot	her: 4  Nursing H	lome 5 Resid	dence 6 🗌 Other (Spe	
A no	eath. or: After the fune	Certificate:	T Natural 5 ☐ Pending 2 ☐ Accident Investigatio 3 ☐ Suicide 6 ☐ Could not be	n 07/13/2010	Uni	njury P• wo		with wa	now injury occurred alker, tripp	umbulating oed on rug and
Divis			4 Homicide determined	28e. Place of Injury - A building, etc. (Spe <b>Son</b> s	t home, far ecify) Home	rm, street, factory, office		28f. Location (S City or Tow Martins	Street and Number or Fi yn, State) 10 Mil burg, W. V	ural Route Number, 1 Staci Dr.
#8-	B Hospit	Medical	(Check 2 L. Medical Exam	sician: To the best of my kr iner: On the basis of examina se Practioner: To the best of	ation and/o	r investigation, in my onin	ion, death occurred	and due to the car	use(s) and manner as s	tated.
,	To the vithin comp		29b. Signature and title of certifier	/		29c. Licen:			29d. Date signed (Mon	th, Day, Year)
			30. Name and address of person who		tem 23a) (T	Type, Print)			7/16/1	0
31	4-12 State		III O MEDICAL CA			HAGER	span ,	MD 217	942	
	Registra	· 1		010	1.	park				

# Please Type or Print in Black Indelible Inko Ensure Ab Capies Are Legible. 20 | 0 23725 State of Maryland / Department of Health and Mental Hygiene

•	1- For State Certificate of Death Registrar Certificate of Death	
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Mooth  Day  Vector	
ivieuicai Examine	Jeffrey S. Patterson July 4, 2010 1720 hrs  4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
	Anne Arundel Medical Center  Annapolis  Anne Arundel	
Funeral Director	5. Social Security Number 220-70-1959 6. Sex 17. Age (In yrs. last birthday) 53 yrs. In Months 17. Age (In yrs. last birthday) 53 yrs. In Months 18. Date of Birth (MM/DD/YYYY) 59. Birthplace (State or Foreign Country) Mary 1at 17. Age (In yrs. last birthday) 53 yrs. In Months 18. Date of Birth (MM/DD/YYYYY) 59. Birthplace (State or Foreign Country) Mary 1at 17. Age (In yrs. last birthday) 53 yrs. In Months 18. Date of Birth (MM/DD/YYYYY) 59. Birthplace (State or Foreign Country) Mary 1at 18. Date of Birth (MM/DD/YYYYY) 59. Birthplace (State or Foreign Country) Mary 1at 18. Date of Birth (MM/DD/YYYYY) 59. Birthplace (State or Foreign Country) Mary 1at 18. Date of Birth (MM/DD/YYYYY) 59. Birthplace (State or Foreign Country) Mary 1at 18. Date of Birth (MM/DD/YYYYY) 59. Birthplace (State or Foreign Country) Mary 1at 18. Date of Birth (MM/DD/YYYYY) 59. Birthplace (State or Foreign Country) Mary 1at 18. Date of Birth (MM/DD/YYYYY) 59. Birthplace (State or Foreign Country) Mary 1at 18. Date of Birth (MM/DD/YYYYY) 59. Birthplace (State or Foreign Country) Mary 1at 18. Date of Birth (MM/DD/YYYYY) 59. Birthplace (State or Foreign Country) Mary 1at 18. Date of Birth (MM/DD/YYYYY) 59. Birthplace (State or Foreign Country) Mary 1at 18. Date of Birth (MM/DD/YYYYY) 59. Birthplace (State or Foreign Country) Mary 1at 18. Date of Birth (MM/DD/YYYYY) 59. Birthplace (State or Foreign Country) Mary 1at 18. Date of Birth (MM/DD/YYYYY) 59. Birthplace (State or Foreign Country) 59. Birthplace (Stat	nd
,	Usual Residence of Decedent  10a. State 10b. County 10c. City. Town or Location 10d. Inside City. Lim	
yland -f show an once.	Maryland Anne Arundel  Annapolis  Annapolis	
th the Maryland 23a or 28a-f sh cotified at once	104 Conduit Street 21401 USA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status 1  Never Married 2  Married 2  Married 3  Widowed 4  Divorced If Yes, Give Year 1  Yes 2  No 3  Widowed 4  Divorced If Yes, Give Year 1  Yes 2  No 3  No specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Specify:  Spec	
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6 72 ho un "na cal Ex lete	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)	
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exau Completed	12 Mailroom Supervisor State Government  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surgame)	
1215- I be filed ental Hyg arked oth vent, the	Francis McCumber Patterson Ruth M. Ritchie	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatite event, the Medical To Be Comple	19a. Informant's Name/Relationship (Type, Print)  Laura Patterson - Wife  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  104 Conduit St., Annapolis, MD 21401	
more, Pages 1 an ent of Hea nt: If ites	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify  20b. Place of Disposition (Name of cemetery, crematory or other place)  Hillcrest Mem. Gardens 7/9/2010 Annapolis, MD	
altir mit. P partme porta ury or	4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  John M. Taylor Funeral Home	_
W 6 0	Myelin T. Klobert per DVK 147 Duke of Gloucester St., Annapolis, MD 2140	01
Physician /M i I Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease  Approximate Interv Between Onset an Death	
	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.	
iner	if any, leading to immediate Due to (or as a consequence of):	П
60, are be executed hysician and the burial - transit Medical Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	_
760, icate be executed the burial - transit	d.	
'60, ate be e	UNPENDED AMENDED  1F FEMALE: 23d. Date of delivery	
ox 687 ath certific attending jor use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year	
O. BC nat the der dd by the a etached fo	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?	_
s, P.O. uires that th n signed by d be detach ed by P	Hypertension, Hypercholesterolemia, Renal Disease, Chronic Alcohol Use  1 ✓ Yes 2 No 3 Probably 4 Unknown	1
Records, The law requires ficate has been sig page 2 should be Completed	24a. Was an autopsy findings available performed?	
tal Recitian: The certificate	25. Was case referred to medical       26. Place of Death (Check only one)       27. No       1 ✓ Yes       2 ◯ No       No	$\dashv$
F Vita	examiner? 1 Yes 2 No  Hospital: 1 Inpatient 2 FR/Outpatient 3 OOA  Other4 Nursing Home 5 Residence 6 Other.	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the stater death. It is after death. There this certificate has been signed by led in by the funeral director, page 2 should be detach retification: To Be Completed by Prification: To Be Completed by P.	27. Manner of Death  1 V Natural 5 Pending 2 Accident Investigation  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No  28d. Describe how injury occurred	
Division o spital or Attending hours after deer After neral Director: After filled in by the fune Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	у
To the Hospita within 24 hours To the Functal completely fille	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
F % F 2	29b Signature and title of certifier 29d. Date signed (Month, Day, Year)	$\exists$
	Ciclo Ville ( ell ) O.C.M.E. July 5, 2010	
100	30. Name and address of person who completed cause of death (Item 23a)  Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registrar	31. Date filed (Month, Day, Year) 22. Registrar's Signature	٦
DHMH 17 Rev 1/2001	OCME ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Gary Prillaman July D2010 14 11:25 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's County 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 8. Date of Birth **Funeral** 1 **X** M 2 □ F Days Hours 09-06-1927 Director 82 136-22-9680 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits MD Calvert Lusby 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 705 Berry Drive 20657 United States Was Deceded Argued Forces?
1 XI Yes 2 1945–1946 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Divorced 4 Divorced Specify: White ed other than "natur event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other thin any injury or other them. Office Equipment Service Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gerry Ivan Prillaman Gladys Irene Lester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Allen Prillaman Wife 705 Berry Drive, Lusby, Maryland 20657 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 

 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 7/22/2010 Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P. A. P. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ MRSA proumonia disease or condition / Medical resulting in death) Examiner chronic destruction end-Stag Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Anauma laid Division of Vital Records, Completed Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy resolfailure. Diaheles mellilus 1 ☐ Yes 2 ☐ No or Attending Physician; 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No 124 hours after death le Funeral Director: A pleted filled in by the f Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. a causa(s) and hild her as state 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) Sicklifull INTERNI'ST D263173 07/14/2010.

DHMH 17 Rev 7/2009

6+1

Registrar

State

.GONARDTOWN, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

16 2010

R. SIRDIBUIND

32. Registra s Signature

SHAHD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienes A. 1. 0

			1 - For State Registrar	State of IVI	aryland	Cei	artment of F tificate of L	neaith ar Death	na ivier	птаі Нус	gien Reg. N	2010	2372	7
	Physicia		Decedent's Name (First, Middle,  CLARENCE	Last)	PRT	NGLE	JR.			Date of Dea Month JULY		ay 2010 Year	3. Time of Death 1:59 A	
	Medic Examin		4a. Facility Name (if not institution,		- 111	III DEL	4b. City, Town, or	Location of D		оп.	$\neg \neg$	c. County of Deat		
-/	Ermanal		5817 SACHEM I		e (In yrs. las	t hirthday)	FOREST If Under 1 Year	HEIGHT		Date of Birt		PRINCE GI		
	Funeral Director		578-64-8131 Usual Residence of Decedent	1 XM 2 □ F 57	e (III yi s. ias	Yrs.	Months Days		Min.	(Month, Day JLY 17	. Yearl	9. Bird Con SOU	hplace (State or Forei intry) ΓΗ CAROLIN	gn A
	aryland a-f shov fied at	Director	10a. State 10b. County		,,	Town or Lo							10d. Inside City Limit	
	or 28	Dire	MD PRINCE  10e. Street and Number	GEORGE'S	FO.	REST	HEIGHTS 10f. Zip Code	-			10a C	itizen of What Co		NO
	s 23a ust b	Funeral	5817 SACHEM DRI	VE			20745				USA			
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important if firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☒ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? ed 1 X Yes 2 I If Yes, Give Year or Dates.		v l	Was Decedent of Hi f Yes, specify Cuba ☐ Yes 2 🏋 No	n, Mexican, P	? (Specify Puerto Rica	Yes or No-		14. Race - Amer Black, White Specify: BLA	e, etc.	
21215-0036	in 72 hou e. ian "natu Medical	Be Completed	15. Deceden (Specify only highes Elementary/Seconday (0-12)	's Education t grade completed)  College (1-4 or 5	i+)	(Give I	lent's Usual Occup kind of work done o O NOT use retired)	ation during most of	f working		16b. l	Kind of Business I	ndustry	7
7	d with lygien ther th nt, the	č	12TH			DII	RECTOR					IVATE		
Maryland	be file ental H ked or c ever	다 B	17. Father's Name (First, Middle, La CLARENCE PRINGL	•				18. Mother's BESS		st, Middle, I SEDDIE		Surname)		
ary	hould and Mi s mar umati		19a. Informant's Name/Relationshi	<del></del>		19b. Mailir	ng Address (Street a					r Town, State, Zip	Code)	
<b>∑</b> 3	ind 2 s lealth a m 27 i		DONNITA PRINGLE	/WIFE		5817	SACHEM D	RIVE F	OREST	HEIG	HTS	,MARYLAN	ID 20745	
Baltimore,	tge 1 ant of H		20a. Method of Disposition  1 ▼ Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp.	3 ☐ Removal from State	cer	metery, cren	sition (Name of natory or other plac		Date			ocation - City or		
alti.	mit. Pa bartme bortan r injury		4 ☐ Donation 5 ☐ Other (Sc. 21. Signature of Funeral Service Lie		RES		CION CEME  . Name and Addres					NTON, MAR S FUNERA		
Ä	permi Depar Impo any ir		LA A				7474 LAND							
P	nysician/ Medical		23a. Part 1. Enter the disease, or o shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	ly one cause on each line	ATIC (	CANCER	er the mode of dying			piratory arre	est,		Approximate Interval Between Onset and Death	
	Examiner	L	Sequentially list conditions,	h										
7	sit s	Examiner	cause. Enter Underlying Cause (Disease or linjury	Duale (sease	гох весие	nte ciy:								
760	physician and the burial-transit	Exal	that initiated events resulting in death) Last	c. Due to (or as a	conseque	nce of):				-				
760	nysicia ne buri	ledical I		d										
	2 (7)	/Me	IF FEMALE:	23c. If yes, outcome	of pregnance	21/					$\neg$			
Box	by the attending ached for use as	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1  Live Birth 4  Pregnant at 9  Unknown	2 🗌 Fetal o	death 3	Ectopic pregnanc Other (specify)	y 			27	23d. Date of deli Month	very Day Year	
	been signed by the should be detached	و ک	Part II. Other significant condition	s contributing to death b	ut not result	ting in the u	nderlying cause giv	en in Part I.					the cause of death?	wn
Sord	as beer 2 shou	Completed							_ }	24a. Was a	n	24b. Were aut	opsy findings available	е
Rec	certificate has	Com								autops perform	med?	death?	ompletion of cause of 2 🔀 No	
ital	is certific director,	Be	25. Was case referred to medical examiner?	Hospital:			26. Pla	ace of Death (C						
	er this neral dir	e: 10	1 ∐ Yes 2 ☒No 27. Manner of Death	1  Inpatie	y 2	8b. Time of	t 3 DOA 28c. Injury	4 ☐ Nursin		5 X Reside		Other (Special	<u>[y]</u>	_
On o	eath. or: After he funer	ficat	1 X Natural 5 Pending 2 Accident Investiga	tion	Year)	injury	work'	? Yes 2□No	- 1	2001100110	,	y coodinod		
> 5	rs after deatf	al Certificate	3 Suicide 6 Could not 4 Homicide determin			e, farm, stre	et, factory, office			Location (St City or Town		d Number or Rura )	al Route Number,	
he Hospi	within 24 bound after deat  To the Funeral Director: completed filled in by the	Medical	(Check 2 \( \subseteq \textbf{Medical Ex} \)	Physician: To the best of a miner: On the basis of ex furse Practioner: To the b	amination a	ınd/or investi	gation, in my opinio	n, death occum	red at the t	ime, date an	d place	and due to the ca	ause(s) and manner sta	ited.
Į.	0		29b. Signature and title of certifier	(A)	( July	)		License number 29d. Date signed (Month, Day, Year)						
	3	ŀ	30. Name and address of person wi	no completed days of de	ath /Item 2	3a) (Type P	D7080	)1			JU	LY 15, 2	010	
	EL.		DAVID J. PERR				ET N.W. 7	C2151	WASH	INGTO	N,D	C 20010		
	Stat Registra	_	31. Date filed (Month, Day, Year) <b>J</b> UL 1 6 2010	32. Registra		e West								

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 201<u>0</u> Bertha Morgan Plater 12:10 P M July Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care Potomac Montgomery 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs Funeral 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 579-58-8161 1 M 2 X F 104 Months Days Hours Min. 08/16/1905 Director Mary Land Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Kensington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20895 3711 Astoria Rd United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.' Black. White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 🔀 Widowed 4 🗌 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highe est grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Typist Federal Govt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edith Thomas George P. Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3711 Astoria Rd, Kensington, MD 20895 Edith Plater Stockton/Daughter 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 7-15,2010 4 Donation 5 Other (Specify) Mt. Olivet Cemtery Washington DC 21. Signature of Funeral Sertica Licenses 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fhysician/ 0 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed the form that the death.

Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Other (specify) Day Year Pregnant at time of death 9 Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 1 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🔀 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 XNursing Home 5 Residence 6 Other (Specify) nours after death.

neral Director: After this
dilled in by the funeral di Certificate: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1X Natural iniury 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certific

31. Date filed (Month, Day, Year)

15 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Roy Friend, M.D. 7758 Wisconsin Ave, #211, Bethesda, MD 20814

29c. License number

D34590

29d. Date signed (Month. Day. Year)

July 12,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2010 Year 6:00 рм Judith H. Plotkin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Renaissance Gardens - Riderwood Silver Spring Prince George's Social Security Number 8. Date of Birth (Month, Day, Yea Aprul 06. 9. Birthplace (State or Foreign Country) 5. 1924 Massachusetis If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2 X Hours **Director** 018-18-5026 86 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 💢 No Maryland Montgomery Silver Spring 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3128 Gracefield Rd.. Apt. HS-519 20904 u.s.A 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. artment of Health and Mental Hygiene. Ortant: If item 27 is marked other than "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: 3 Widowed 4 Divorced Completed White the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Math Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cornelius Helpern Martha Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Henry Plotkin - Spouse 3128 Gracefield Rd., Apt HS-519, Silver Spring, MD20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of I 1 🕱 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance 07/18/2010 | Clarksburg, Maryland any Injury Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Amyotrophic Lateral Sclerosis Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated event resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Day 5 Other (specify) Month Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Alzheimer's Disease 1 Yes 2 No 3 Probably 4 LUnknown Completed Osteoporosis 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe Degenerative Joint Disease & Spinal Stenosis 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 2 🛛 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗓 Natural  $5 \square$  Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 | 3 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D44156 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Grace

3110

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. N 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year Physician Roberts Leonard 844 4 2010 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8528 Jalkersville Place For tune Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex **Funeral** Days Hours Min. Year) 1 XM 2 □ F 219-48-3286 Director 60 Aug 23, 1949 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. item Z is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is "inclined at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8528 Fortune Place United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 TXYes 2 No If Yes, Give Year or Dates: 1 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: <u>ک</u> Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, If I made. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic Flooring 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Aravilla Irene ပ Carl Teo Roberts Wagner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine A. Earls/sister Walkersville, Maryland 21793 8528 Fortune Place 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 7/16/2010 Woodbine, Maryland 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 21. Signature of Funeral Service Lice iante M00957 23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Nhknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autonsy perform 2 **2** No 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 XXVo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Director; After Watural . 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Funeral 29a. Certifier 📂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 24 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12+ Year) 16 31. Date filed (Month, Day, Fegistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 07 / 149/2010 Year Elizabeth Lucy Ryan 03:00 ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Millersville Knollwood Manor 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 NY 8. Date of Birth **Funeral** 1 M 2 x F 85 Days Hours 075-18-0580 0872271924 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Calvert Huntingtown 1 🗌 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2061 Lowery Oak Lane 20639 U.S.A. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. "natural", 3 X Widowed 4 Divorced Specify: Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F 27 is marked of traumatic ever permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked cany injury or other traumatic evence. ဂ္ John Lyons Julia Lyons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert John Ryan/Son 2061 Lowery Oak Lane, Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 D Removal from State Lee Crematory 07/15/2010 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Lisa M. Southern Md Blvd. . Owings. MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line, Immediate Cause (Final Onset and Death PNEUMON14 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (of as a soft-sequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 Wo 5 Other (specify) Month Year Pregnant at time of death Day 1 L Yes 2 L g L Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an safter death.

I Director: After this certificate has the second of the second director, page 2.5 autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: မ 1 🗌 Yes 2 1 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature at 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) arw CBRIDE RD BALTIMORE LACE 32. Registra s Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Theresa Mary Reed 2236 <u>J</u>u1 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F 219-14-1863 April 23, 1924 Maryland Director 86 Usual Residence of Decedent shov 10b. County 10a. State r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director Port Deposit Marvland Cecil 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21904 U.S.A. 22 Robin Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 V Married 1 Yes Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: and Mental Hygiene. is marked other than "natural", 3 Divorced Specify: White Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Cecil County Public Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria & Library Assistant Schools, Elkton, MD <u>Twelve Years</u> permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Antonio R. Sacco Marie A. Forlino 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Robin Drive, Port Deposit, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State
Havre de Grace,
Maryland Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Erin Cemetery 07/21/10 ^{22. Name and Address of Facility}
Lee A. Patterson & Son Funeral Home,
Perryville, Maryland 21903-0766 Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death Physician/ Myocardial disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and s the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last un known anemia Due to (or as a consequence of) Physician/Medical certificate be Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown ate has been signed by the atte page 2 should be detached for Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy Yes 2 No 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ιê 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director, A 1 Yes 2 No Investigation 6 Could not be 2 Accident 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioners to the best of my knowledge 29b. Signature and the of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper Chesapeake Drive, Bel Air, MD 21014 FISHER IND 61. Date filed (Month, Day, Year)

Registrar

JUL 19 2010

2010

rero

32. Registrar's Signatur

State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 07/13/2010 4:30A Marjorie Burch Reznek /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Asbury Methodist Village Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) **Funeral** Days Hours Months Pennsylvania 91 171-12-7738 **Director** 07/10/1919 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show Injury or other traumatic event, the Medical Examinar must be notified at Director 1 TYes 2 □ No MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 United States 415 Russell Avenue #610 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 ò Specify: White 1 ☐ Yes 2 【XNo Specify: þ If Yes, Give Year or Dates 3 Widowed 4 □ Divorced marked other than "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be I Department of Health and Mental Important: If Item 27 Is marked o Agnes Chaplow Walter Burch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1531 44th Street NW Washington, DC Sarah Reznek/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 07/14/2010 National Crematory Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Service License 5130 Wisconsin Ave., NW Washington, DC 20016 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Commonth. **Physician** ngester e hearto /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician a 4 for use as the burial-transit Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d, Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy page performed penal stenson 1 ☐ Yes 2 🗷 No 2 . Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 🗹 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥ 04-115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 RUSSEL HROBERT BIRSCHBALLET MID 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registrar

			for State Registrar	State of Marylan	Cer	tificate of L	Death	vientai ny	Gleri Reg. N		23734		
	Physicia	n/	1. Decedent's Name (First, Middle, La		T		· · · · · ·	2. Date of De Month July		ay 2010	3. Time of Death		
	Medic Examin	al	Hall  4a. Facility Name (if not institution, give	rry West Straho	orn, Jr		Location of Death		$\overline{}$	L ZOTO c. County of Death	2340 P ^M		
-	Examin	eı	270 Fair Hill Dr			E1ktor				Cecil			
Ī	Funeral Director		5. Social Security Number 6. S		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da OCT 14	th ay, Year)	9. Birth Cour Ma	place (State or Foreign htry) 1 ry land		
	show d at	tor	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Loc	cation					10d. Inside City Limits		
	Mary 28a-f otifie	irec	Maryland Cecil		Elkton						1 🗌 Yes 2 ី No		
	ith the 23a or st be n	<b>Funeral Director</b>	10e. Street and Number 270 Fair Hill Dr	rivo		10f. Zip Code 21921			-	itizen of What Cou United St	-		
	eath w tems?	Fune	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. V	Vas Decedent of Hi Yes, specify Cuba		ecify Yes or No-		14. Race - Americ	can Indian,		
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by I	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Yes 2 X No		Hican, etc.)		Black, White, Specify: Wh:	etc. ite		
15-0	should be filed within 72 hours after and Mental Hygiene. 'Is marked other than "natural", ' raumatic event, the Medical Exan	plet	15. Decedent's l (Specify only highest g		(Give k	ent's Usual Occup		king	16b.	Kind of Business In	ndustry		
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pu	filed valued Hyg	Be c	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,	Maider				
ylaı	Ment Ment narke	오	Harry West Strah		1		Daisy N	loore					
Maryland	2 shot th and 27 is n traum		19a. Informant's Name/Relationship (		1	•			-	or Town, State, Zip 21921	Code)		
	1 and of Heal item 2		Paul Andrews Str	20b. F	Place of Dispos	Fair Hill sition (Name of patory or other place		Date 26,		Location - City or T	own, State		
Baltimore,	Page ment c ant: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	I hemoval nom state	Sharps	Cemetery	2010	)		Fair Hil			
Balt	permit. Depart Import any inj once.		21. Sign ture of Funeral Service Licer	nsee High	22					or Funera lkton, MI			
	Physician/	8	23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.				or respiratory ar	rest,		Approximate Interval Between Onset and Death		
Ŧ	Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a.   **MOCARDIAL INFACTION**  Due to (or as a consequence of):  CORONALY ANTEN DISEASE										
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Due to (or as a consequ		EXT DI	7FA7E				YEARS		
	scuted and transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. HYPERT		W					YEAKS		
092	cate be executed physician and the burial-transit	/ledical E	resulting in death) Last	d. HYPERLIV	,	И					YEARS		
. Box 687	ath certific attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1  Live Birth 2 Feta 4 Pregnant at time of 0 Unknown	al death 3 🗌	Ectopic pregnanc	у			23d. Date of deliv Month	very Day Year		
ls, P.O.	uires that the ded is signed by the did signed by the did signes		Part II. Other significant conditions	contributing to death but not res	sulting in the u	nderlying cause giv	ren in Part I.				he cause of death?		
Division of Vital Records,	The law require cate has been si page 2 should l	Completed by						24a. Was auto perfo		prior to co	ppsy findings available ompletion of cause of		
tal	iician; The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		26. Pl	ace of Death (Che	ck only one)					
of Vi	Physical direction	e: To	1 Yes 2 No 27. Manner of Death	1 Inpatient 2 2 28a. Date of injury	28b. Time of	t 3 DOA 28c. Injun	4 LJ Nursing H	ome 5 Resi		6 Other (Specify	y)		
ono	tending Ph death. tor: After thi the funeral	ficat	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation		injury	M 1 □	? Yes 2 □ No						
Divisi	al or Attendir s after death. al Director: Af ed in by the fu	Certificate:	3 Suicide 6 Could not 4 Homicide determined			et, factory, office		28f. Location (3 City or Tov		nd Number or Rura e)	l Route Number,		
	To the Hospital or within 24 hours after To the Funeral Dirac completed filled in It	Medical	(Check 2 L Medical Exam	ysician: To the best of my know niner: On the basis of examination rse Practioner: To the best of m	n and/or invest	igation, in my opinic	n, death occurred	at the time, date a	and plac	e, and due to the ca	use(s) and manner stated.		
	To t To t		29b. Signature and title of certifier			29c. License	e number		29d. Date signed (Month, Day, Year)  July 32, 2016				
			0								•		
			30. Name and address of person who	completed cause of death (Item 304-306 NOR		rint) KEET S	ALTE #3	ELHTON	ر د	WK LAWO			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend Item 26 per phys. G906 879/10 dk
State of Maryland / Department of Health and Mental Hygiens Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death VIVIAN SWIFT PAULINE Month Day 2010 9, July 1:42 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Wicomico 31871 Downing Road Delmar If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 8. Date of Birth (Month, Day, Year, Sept. 1, 1919 6 Sex 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 F Months Min. 217-30-8202 90 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 No Wicomico Delmar Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21875 31871 Downing Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 □Yes 2 No Specify: Specify: 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Pharmacy Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mae Collins Bert Paugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4769 Poplar Street - Crisfield, MD 21817 Betty L. Stering (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 12,2010 Crisfield, Maryland Sunnyridge Memorial Park 21. Signal of Funeral Service

Mary Beth Br 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, Maryland 21817 Bradshaw-Pruitt 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): ID Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnan 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy 25. Was case referred to medic examiner? 1 ☐ Yes 2 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ 🗖 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a. State

**Funeral** 

Director

28a-f show

Director

by Funeral

Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Investical Examinations and Injury or other traumatic event, If a Investical Examinations and Injury or other traumatic event, If a Investical Examinations and Injury or other traumatic event, If a Investical Examinations are consistent and Injury or other traumatic event, If a Investical Examinations are consistent and Injury or other traumatic event, If a Investigation and Injury or other traumatic event, If a Investigation and Injury or other traumatic event, If a Investigation and Injury or other traumatic event, If a Investigation and Injury or other traumatic event, If a Investigation and Injury or other traumatic event, If a Injury or other traumatic event, If a Injury or other traumatic event, If a Injury or other traumatic event, If Injury or other traumatic event, If Injury or other traumatic event, If Injury or other traumatic event, If Injury or other traumatic event, If Injury or other traumatic event, If Injury or other traumatic event, Injury or other traumatic event, Injury or other traumatic event, Injury or other traumatic event, Injury or other traumatic event, Injury or other traumatic events are considered and Injury or other traumatic events are considered and Injury or other traumatic events are considered and Injury or other traumatic events are considered and Injury or other traumatic events are considered and Injury or other traumatic events are considered and Injury or other traumatic events are considered and Injury or other traumatic events are considered and Injury or other events and Injury or other events are considered and Injury or other events are considered and Injury or other events are considered and Injury or other events are considered and Injury or other events are considered and Injury or other events are considered and Injury o

Baltimore, Maryland 21215-0036

Examine burial-transit attending physician and Physician/Medical the as asn ξ

certificate be executed

law requires that the death

The

this funeral

After 1

after death Director:

within 24 hours aft To the Funeral Di completely filled in

To the I within 2

death.

Box 68760

P.0.

Records,

Division of Vital Hospital or Attending Physician: ed by the detached f signed à director, page 2 should be Completed been : has certificate Be

27. Manner of Death

1 Natural

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a. Certifier

Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier meno

5 Pending investigation

6 Could not be determined

29c. License number

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day, Year)

and manner stated.

Ziemer, Elleda - 100 Power Street - Salisbury, MD 21804 M.D. 31. Date filed (Month, Day,

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

State Registrar

Certification: To

Medical

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 23736 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gerard Gregory Schenning T111 v 2010 06:10p.m Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, March 29 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Country)
Maryland Director 212-48-5012 63 March Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Ħ Director ed other than "natural", or items 23a or 28a-f s event, the Medical Examiner must be notified 1 Yes 2 X No St. Mary's Charlotte Hall Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29449 Charlotte Hall Rd. 20622 Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. ģ 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White Completed 3 - Widowed 4 X Divorced Year or Dates 1967 - 1971 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Security Agent Federal Government 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Schenning Mildred Groncki traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David C. Schenning/Brother Pebble Beach Drive, Ellicott City, MD 21042 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important; If ite any injury or ot 7-29-PP 1 👿 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗋 Donation 5 🗆 Other (Specify) Cheltenham, Maryland Maryland Veterans Cemetery M00817 Name and Address of Facility
Brinsfield-Echols Funeral Home, P.A.
P.O. Box 128 Charlotte Hall, MD 20622 21. Signature of Fune al Service License 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Dea Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a conseque **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to for as a nonsequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral interestor, page 2 should be detached for use as the burnal-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death Yes 2 □ No g Unknown g Unknown Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 **☑** No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \( \sum \) Yes 2 \( \overline{N} \) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

101 Cen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regi trar's Signature

AMIRM, ALIKHANI

31. Date filed (Month, Day) (44r)

+6046

aplata, MD

20646

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Catherine 07 09 Sharpe 2010 7:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Caroline Hospice Denton er 1 Year | If Under 24 Hrs. Home Caroline If Under Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) Funeral Months Days Hours Min 1 □ M 2 🖫 F Director 90 Maryland 194-12-0313 05-20-1920 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Md. Caroline Preston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4139 Harmony Road 21655 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: ģ 3 ⅓Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hurlock Sportwear Seamstress traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If then 27 is marked oth any fluiry or other traumatic event any fluiry or other traumatic event once. Be မ Linwood Dotson Wadsworth Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) r | 4802 Webster St Federalsburg, Md. 21632

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date | 20c. Location - City or Town, State Shirley Small / Daughter 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Denation 5 Dother (Specify) 07-14-10 | Hurlock, Maryland Md. Veterans Cem. 21. Signature of Fune of Service Licensee 516 S.Main Street, Hurlock, Md. 21643 7/2 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 2 No been signed by the sahould be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate 2 No 1☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) address of person who completed cause of death (item 23a) (Type, Print) 30. Name 8 920 31. Date filed (Month, Day, Registrar's Signature Year) State JUL 12 2010

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #6per Middle. Last) 7/23/10 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FRANCIS JULY **SERRY** 09 18:30 P M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 07-26-195] 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🔀 58 WEST AFRICA 579-17-6003 Director Usual Residence of Decedent ms 23a or 28a-f shov must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD PRINCE GEORGES 1X Yes 2 I No UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9509 MERIKERN LANE 20774 USA "natural", or item ledical Examiner n 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc þ 1 Never Married 2 Married 2 X No 1 Tes : Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK Completed 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) the Me Elementary/Seconday (0-12) College (1-4 or 5+) 5+ filed within tal Hygiene. permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other this am injury or other traumatic event, the PRIVATE PHLEBOTOMIST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ SATDU AMINATA BANGURA SERRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9509 MERIKERN LANE, UPPER MARLBRORO, MD 20774 **JERIDINE** SERRY / WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗀 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 7/28/2010 SIERRA LEONE, WA RONNIETTA ESTATE 21. Signatus of Fareral Se 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 LANDOVER RD., LANDOVER, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ HEPATOCELLULAR CARCINOMA STAGE 4 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CHRONIC HEPATITIS B Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown this certificate has been signed by ral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1  $\square$  Yes 2 X No 3  $\square$  Probably 4  $\square$  Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🕅 No Hospital: Other: 1  $\square$  Yes မ 1 🖾 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) nours after death.

neral Director: After the filled in by the funera 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours a To the Funeral D 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52503 JULY 12, 2010

14 State

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year

JUL 1 6 2010

SHAILERH SHETH. MD. 1500 FOREST GLEN ROAD, SILVER SPRING, MD 20910

to completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Month **Physician** 4:40BM Juli ames /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Future Care Pineview Nursing Home Clinton 9. Birthplace (State or Foreign Country) North Carolina 8. Date of Birth (Month, Day, Oct. 3, 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days 1 2 M 2 □ F Hours Min. 1921 Director 246-16-6140 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show event, the Medical Examiner must be notified at 1 AYes 2 No Director Prince George's Clinton Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or United States 20735 9106 Pine View Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 AYes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after thealth and Mental Hygiene. Health and Mental Hygiene. Iom 27 is marked other than "natural", or Itel 1 ☐ Never Married 2 ☐ Married African 1 ☐Yes 2 No Specify. If Yes, Give Year or Dates: \$ 3 Nidowed 4 Divorced American
16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4th Construction Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Albert Smith Pannie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joan Elizabeth Smith/ Daughter 617 Brookedge Court Mitchellville, Md. permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition July 15, 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 2010 Brentwood, Maryland 21. Signature of Funeral Service Lica 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019 Approximate Interval Between Onset and Death 23a. Pa 11. Ly ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Staye **Physician** End /Medical Due to (or as a consume nce of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hyper Caleni 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a, Certifier 🖅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check of one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12 2010 00053337 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste 203 Baltrune 2835 SmHyAverue 31. Date filed (Morkh, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

JUL 1 5 2010

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23740 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 8, 12:32 A M Sparks 2010 Dona Υ. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Prince George's 4b. City, Town, or Location of Death **Examiner** Ft. Washington 10107 Old Fort Place 5. Social Security Number . Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Jan. Zay, Year 1917 1 M 2 K F Months Days Hours. North Carolina 231-22-5599 93 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director Prince George's 1 X Yes 2 □ No Maryland Fort Washington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Page 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hyglene. The mattrall, or items 23a ant. If item 27 is marked other than "natural", or items 23a ury or other traumatic event, the Medical Examiner must barry or other traumatic event, the Medical Examiner must barry or other traumatic event, the Medical Examiner must barry or other traumatic event, the Medical Examiner must barry or other traumatic event, the Medical Examiner must barry or other traumatic event, the Medical Examiner must barry or other traumatic events. Funeral 10107 Old Fort Place 20744 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces2 1 Yes 2 No Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify: If Yes, Give 3 → Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private 12th Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eliza Cozart Foster Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10107 Old Fort Place Fort Washington, Md. 20744 Allien Y. Johnson/ Daughter permit. Page 1 and 2. Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗔 Removal from State 13, Lee's Crematory Clinton, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, natu of Funer So ice Li 4001 Benning Road NE Washington, DC 20019 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Alzheimer disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Hypertension Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): s been signed by the attending physician should be detached for וומם סיים איזי Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year Day Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 2 🔼 No 1 Tes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 A Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State

Bahram Redjaee, M.D. 4467 Old Branch Ave., Suite 201

31. Date filed (Month, Day, Year)

32. Registry's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

D0039691

July 12, 2010

Temple Hills, Md.

20748

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 23741 for State Registrat Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $J_{\mathbf{u}}^{\text{Month}}$ Physician/ Fred Hugo Sanderson ^{Day} 2010 10, 12:30 Αм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 5017 Westport Road Chevy Chase 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days (Month, Day, Year) 4/15/1914 1 **X** M 2 □ F Yrs Director 96 083-36-1838 Germany Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c, City, Town or Location 10d, Inside City Limits death with the Maryland Director r than "natural", or items 23a or 28a-f s the Medical Examiner must be notified. 1X Yes 2 ☐ No MD Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 5017 Westport Road 20815 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Economist U.S. State Department 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Siegfried Samson Maria Schulze 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Stafford / Personal Rep. 1320 Old Chain Bridge Rd #205 McLean, Va. 22101 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 7/21/2010 4 ☐ Donation 5 ☐ Other (Specify) Creek Cemetery Washington 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. Wil 5130 Wisconsin Ave. NW Washington, DC 20016 used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that a shock, or heart failure. List only one cause on ea Interval Between Onset and Death Immediate Cause (Final Physician/ a Sudden Cardiac Death minutes disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 15_years Aortic Valve Disease Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Atrial fibrillation Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 24 hours after death.

• Funeral Director: After this certificate haland dilector, pag. 1 ☐ Yes 2 ☐ No 2 X No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 12 1 Yes 2**X** No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 5 Pending 1 XNatural work 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

within 2.

To the F 2

> State Registrar

Medical

29a. Certifier

only one 29b. Signature and title

Dr Allen A. Nimitz

15

31. Date filed (Month, Day, Year)

JUL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signat

Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

7/12/10

29c. License number

5530 Wisconsin Ave #700 Chevy Chase, Md 20815

D07147

			1 - State of Ma	ryland / Depa <i>Cer</i>	artment of F	lealth and N Death	Mental Hygid	ene 2 0	0	23742
	Dhominin	- /	Decedent's Name (First, Middle, Last)				2. Date of Death Month		rear	3. Time of Death
	Physicia Medic		Roger Lee Swope. S	Sr.			7-	15-10	)	1157pm
	Examin	er	4a. Facility Name (if not institution, give street and number)  Carroll Hospital Center		4b. City, Town, or Westmi	Location of Death .nster		4c. County of Carr		
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	ld st	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	cation				100	I. Inside City Limits
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	the M	l Dir	10e. Street and Number		10f. Zip Code		10	g. Citizen of Wh	at Countr	1?
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9	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at		11. Marital Status  1 Never Married 2 Married  12. Was Decedent Every Arrived Forces?  1 Never Married 2 Married	1070	f Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Black,	Americar White, etc	
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Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) Donald Lee Swope			18. Mother's Name	e (First, Middle, Ma Olive	^{iden Surname)} Palme	r	
Mary	2 should th and N 27 is ma traumat		19a. Informant's Name/Relationship (Type, Print) Roger Lee Swone. Jr. / Son	and Number or Rura				eh SC 2957		
ē,	of Healt of Healt fitem 2		20a. Method of Disposition	20b. Place of Dispo		-		0c. Location - C		
<u>m</u>	Page Thent o ant: If ury or		1. ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	21-2010 н	Hagerstown Maryland					
Balt	permit. Page 1 Department of Important: If i any injury or once.	A OF	21. Signature of Funored Service Licensee			s of Facility Bas ational B				Nome PA 21713
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x 687	death certificate be executed he attending physician and ed for use as the burial-transi	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2	f pregnancy	Ectopic pregnanc	v		23d. Date	-	
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Sec	sician: The law certificate has l lirector, page 2 s	Completed	HYPERTENSION ACUTE RENAL FAI	LIRE			autopsy performe 1 □ Yes 2	pri de: No 1	or to comp ath? ] Yes 2	bletion of cause of
ta Ta	cian: T		25. Was case referred to medical examiner?	- (COV - VOP)	0174	ace of Death (Check		W		
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o n	Attending Phys er death. ector: After this by the funeral di	icate	Natural 5 ☐ Pending (Month, Day, 2 ☐ Accident Investigation		work'		26d. Describe now	injury occurred		
Division of Vital Records,	I or Attence after death Director:	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc.	y - At home, farm, stre (Specify)	eet, factory, office		28f. Location (Stree City or Town, S		or Rural R	oute Number,
	To the Hospital or a within 24 hours after to the Funeral Dire completed filled in L	Medical	29a. Certifier Check 2 Medical Examiner: On the best of m	amination and/or invest	igation, in my opinio	n, death occurred at	the time, date and	place, and due to	the cause	(s) and manner stated.
	To the within to the somple	Σ	only one) 3	est of my knowledge, d	leath occurred at the 29c. License			use(s) and manr d. Date signed (i		
			· Inde	- mo	DE	30263		7-16-	10	
ر اک	H-15+1		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type, P	rint) WHOVE	, WEST	NINSTE	P, Mr.	21	157
	Stat Registra		31. Date filed (Month, Day, Year) JUL 19 2010  32. Figistrar'	s Signature	aster					

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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and show 1 at	į	Usual Residence of 10a. State	Decedent 10b. County		10c. City	y, Town	or Locat	ion								10d. Inside City Limits
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permit. Departr Imports any inji		21. Signature of Fur	neral Sen ce Lic	nsee			22. N	lame and	Address	s of Facil	^{ity} Osb eague	orne F	une	ral H	lome,	P.A. .,MD 21795
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Physician/ Medical Examiner		disease or condition resulting in death)		a. Due to (or as	a consequ	uence of	<u> </u>	no	<u> </u>	tre:	UVY	>VV \				
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law requires that the death certificate be as been signed by the attending physici is 2 should be detached for use as the bu		IF FEMALE: 23b. Was decedent in the past 12 1  Yes 2 9  Unknown	wonths? No	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant : 9 ☐ Unknown	2 🗌 Feta	al death		Ectopic pre Other (spe		y					ite of del	ivery Day Ye <b>a</b> r
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The law requate has been page 2 shou	Completed												opsy formed		Were aut prior to o death? 1  Yes	topsy findings available completion of cause of
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pital or Attendi ours after death, eral Director: A filled in by the fu	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	t be			n, street	, factory, o	office			28f. Location City or To			er or Rur	al Route Number,
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		For State Registrar		•	Certificate of L		Reg	2010			
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Exami		4a. Facility Name (If not institution			4b. City, Town, or	Location of Death		4c. County of De	eath		
Funeral Director		Good Samarita:  5. Social Security Number  213-42-0523		e (In yrs. last birthd	Months   Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. B	rirthplace (State or Foreign Country) MD •		
and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	r Location				10d. Inside City Limits		
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s 23a	eral	115 E. Melros			21212-		" V - N	U.S.A.			
s after de	by Funeral Director	11. Marital Status  1   Never Married 2   Married 3   Widowed 4   Divorced	12. Was Decedent   Armed Forces?   1 Yes, Give   Year or Dates:	Ever in U.S.	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (S) n, Mexican, Puerti Specify:	pecity Yes or No- o Rican, etc.)	Black, Wh			
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nd 2 shoralth and P 27 is ma r trauma		19a. Informant's Name/Relationsh Suzanne Short		1	lailing Address (Street a				e, Zip Code)		
ages 1 a ent of He nt: If item		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp	•	City or Town, State							
permit. Pages 1 and 2 s Department of Health as Important: If item 27 is any injury or other trau		21. Signature of Funeral Service L		rsalist rsA	Dury Crem	strowski Ostrow	ski rune	Home P.	A		
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):									
ficate be executed physician and sthe burial-transit	ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· Pre	a consequence of):	ia				Unknown		
The law requires that the death certificate be ate has been signed by the attending physicial bage 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1  ☐ Live birth 4  ☐ Pregnant a 9  ☐ Unknown	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of o	delivery Day Year		
uires that n signed b	ρ	Part II. Other significant condition	co use contribute to the cause of death?  2 □ No 3 □ Probably 4 ☑ Unknown								
le law requires t has been signe ge 2 should be o	Completed	Dyslipidemis	, Colon (	ancer	. Chronic	Total	24a. Was an autopsy performe	24b. Were prior t	Were autopsy findings available prior to completion of cause of		
	Be Co	25. Was case referred to medical	ention,	Depre	ssion	26. Place of Dea		No 1 □Y	es 2 No		
hysic his ce I direc	TO B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpatie	ent 2 ER/Outpa	atient 3 DOA Othe	r: 4 ☐ Nursing H	ome 5 Residence	ence 6 Other (Specify)			
Attending Physiclan: r death. ector: After this certific by the funeral director, I	ation:	27. Manner of Death 1 M Natural 5 ☐ Pending 2 ☐ Accident investigs	ition	ry 28b. Tim y, Year) Inju	ry Work	at ? ′es 2 □ No	28d. Describe how	injury occurred			
tal or Atters of all Directo	Certification:	3 ☐ Suicide 6 ☐ Could no determin	28e. Place of Inju- building, etc	ury - At home, farm, c. (Specify)	, street, factory, office		28f. Location (Stree City or Town, S		Rural Route Number,		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (	29a. Certifier 1  Certifying (Check only one) 2  Medical E	Physician: To the best of xaminer: On the basis of and manner sta	f examination and/o	leath occurred at the timor investigation, in my op	ne, date and place pinion, death occu	e, and due to the cau rred at the time, date	se(s) and manner a and place, and d	as stated. lue to the cause(s)		
To th withir To th comp	Me	29b. Signature and title of certifier	ENUCOL, MID		29c. License	number S - 00	I .	. Date signed (Mo			
TLS		30. Name and address of person v		eath (Item 23a) (Ty							

j

State Registrar MARIA MENUCCI 31. Date filed (Month, Day, Year) JUL 12 2010

MD

1D - 5601 Loch Raven Boulevard, Baltimore Maryland21239
62. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 23745 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2:07PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince annam Communit If Under 1 Year If Under 24 Hrs. 9. Birthplace (State of Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 F Months (Month, Day, Year) **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Oyes 2 □ No BOWI 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces Black, White, etc 1 Never Married 2 Married Yes Who Completed by timore, Maryland 21215-0036 1 Yes Who Specify Specify: BlaC If Yes, Give 3 Widowed 4 □ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) rı Va+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lane 10604 Meadow vidge 20a. Method of Disposition

Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 2010 cemere 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Wash. 814 STNW 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examine り Secuentially list our floors Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 4 Pregnant Pregnant at time of death 1 ☐ Yes 21 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Tyes 20 No 3 Probably 4 Unknown Morbiel obesit 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 20 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) Hospital No pital: Inpatient 2 ER/Outpatient 3 DOA

28a. Date of injury
(Month, Day, Year)

28b. Time of injury
injury

28c. မ 1 Tes 28c. Injury at 27. Manner of Death 28d. Describe how injury occurred Certificate: Natural work? 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b, Signature and title of certifier MBD 20069 nott 20170 30. Name and address of person who completed cause of death (item 23a) (Type, Print) HANONER PARKWAY SUITE A. GREENBELT MD 7229 BRAJENDRA 31. Date filed (Month, Day, Year) State 1 6 2010

DHMH 17 Rev 7/2009

Registrar

			For State Registrar	State of N	/iaryiand / L	Certificate of		vientai Hy	/glene Reg. No. 0	0	23746
	Physicia	an/	1. Decedent's Name (First, Mid-					2. Date of De Month	Day	Year	3. Time of Death
	Medi Examir		Richard  4a. Facility Name (if not instituti	Williams on, give street and number)		4b. City. Town, o	or Location of Death	July	20, 201 ( 4c. County o	_	<u> 1953</u> [™]
-	)		Holy Cross	Hospital			ver Spri		Monto		rv
	Funeral		5. Social Security Number		ge (In yrs. last birti	nday) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bii (Month, Da	rth	9. Birthp Count	lace (State or Foreign
	Director		577-04-1677 Usual Residence of Decedent	X	33	Yrs.			13,1977	V	
Maryland 21215-0036	land shov	ţō	10a. State 10b. Coun			10	0d. Inside City Limits				
	Mary 28a-1 otifie	Director	MD	PG	В	rentwood				$\perp$	1 🏿 Yes 2 □ No
	ith the 3a or t be r	ral	10e. Street and Number			10f. Zip Code			10g. Citizen of WI	hat Count	try?
	eath w	Funeral	4502 39th S	12. Was Deceden	Ever in U.S.		722 Hispanic Origin? (Sp.	ecify Yes or No-	United		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 🙀 M 3 ☐ Widowed 4 ☐ Divorce	If Voc Cive		rer in U.S.  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1  Yes 2  No Specify:		Rican, etc.)	Black Specify:	, White, e	etc.
5-0	2 hou "natu edical	plet		dent's Education hest grade completed)		Decedent's Usual Occu (Give kind of work done	during most of work	ing	16b. Kind of Bus		
72	ithin 7 ene. r than	Completed	Elementary/Seconday (0-12)	College (1-4 or		life. DO NOT use retired Glazier	)				
d 2	lled w I Hygi other ent, t	Be	17. Father's Name (First, Middle	, Last)		GIAZIEI		ne (First, Middle,	, Maiden Surname)	riva	te
/lan	d be fi Vental arked rtic ev	욘	Richard T.	Williams S	c				Washingt	on	
lan	shoul and I is ma		19a. Informant's Name/Relation	nship (Type, Print)	19b.	Mailing Address (Street	and Number or Rura	al Route Numbe			ode)
Baltimore, N	and 2 Health em 27		Celestine Ba	aldwin/mot	ner B	502 39th rentwood Disposition (Name of	Street - <del>Md. 207</del>	22	T		
	t Hit		1 🗆 Burial 2 🔀 Crematio	n 3 Removal from Stat	e cemeter	y, crematory or other pla	^(ce)  7/27	/10	20c. Location - C	-	
ij	artme artme ortan injun		4 ☐ Donation 5 ☐ Other  21. Signa are of Funeral Service		River	dale Park 22. Name and Addre	Cremato	ry	Riverd	ale	,_Md
ñ	permi Depar Impor any ir		Janice	Edward	de						Md.20746
			23a. Part 7. Enter the disease, shock, or heart failure. Lis	or complications that cause t only one cause on each li	ed the death. Do no	ot enter the mode of dyir	ng, such as cardiac	or respiratory ar	rrest,		Approximate Interval Between
}	nysician/		Immediate Cause (Final disease or condition Anoxic Encephalonathy								Onset and Death
	Medical Examiner		resulting in death)	Due to (or as	a consequence o	f):					
		ř	Sequentially list conditions,	b. Respi	ratory a consequence of	Failure a	and Seiz	ures		+	
	d ansir	amir	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	•	Nephri					- 1	
	execu an and rial-tra	EX	that initiated events resulting in death) Last	Due to (or as	a consequence o	n:					
00	ificate be executed ig physician and as the burial-transi	dica		d						$\dashv$	
687	ertifice ding p		IF FEMALE:	23c. If yes, outcome	of pregnancy						
Xo	eath certific attending p I for use as	cian	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No	1 🗀 Live Birth		3 ☐ Ectopic pregnan 5 ☐ Other (specify) _	су		23d. Date Mont		ry Day Year
m	requires that the de been signed by the should be detached	hysi	9 Unknown	9 🗆 Unknown							
<u>G</u>	s that gned b	by F	Part II. Other significant condi-	tions contributing to death	but not resulting in	the underlying cause gi	ven in Part I.	11	obacco use contrib		
rds	equire een si ould I	Completed						1 -	Yes 2 No 3	Proba	ably 4 Unknown
ος O	law m has b e 2 sh	mple						24a. Was auto	psy pri	ior to com	sy findings available npletion of cause of
ž	ding Physician; The law h. Affer this certificate has funeral director, page 2		25. Was case referred to medica	, t				1 🗆 Yes	ormed? de 2 No 1	ath? Yes 2	2 1 No
/ita	rsicial s certi	To Be	examiner?  1 Yes 2 No	Hospital:	iont 2 🗆 ED/Out	26. P	lace of Death (Check				
of	g Phy erthis		27. Manner of Death	28a. Date of inj	ury 28b. Ti	me of 28c. Injur	y at		dence 6 Other now injury occurred		
o	eath. or: Af the fur	ifica		tigation	iy, rear)		Yes 2 No				
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Certificate:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide deter	minod 28e. Place of In	jury - At home, farr c. (Specify)	n, street, factory, office		28f. Location (S City or Tox	Street and Number vn, State)	or Rural F	Route Number,
	spital lours a neral C		29a. Certifier 1 Certifyir	ng Physician: To the best o	f mv knowledge d	eath occurred at the time	date and place an	id due to the ca	use(s) and manner	as stated	
	ne Ho n 24 h ne Fur pleted	Medical	(Check 2 \(\sumeq\) Medical	Examiner: On the basis of ng Nurse Practioner: To the	examination and/or	investigation, in my opini	on, death occurred at	t the time, date a	and place, and due to	o the caus	se(s) and manner stated
	Voithi Com		29b. Signature and title of certifi			29c. Licens			29d. Date signed (		
	E		100	W-	MD	DGS	3639		7/21	lio	
-			30. Name and address of person Pothu Nagak	who completed cause of	- 1		ı Cil		- 1115	001	210
	Stat		31. Date filed (Month, Day, Year)	32. Regist	r's Signature	Glen Ro	d., Silve	Spn	rig, MIS.	20	710
	Registra		JUL	292010 ▶/2	MARA L	1. parker					
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			For State		State of I	Marylan	•				and M	lental Hy	_		ì	2371.7	7
	Physicia	ın/	1 - State Registrar Certificate of Death Reg. No. 2 0 0 0 1. Decedent's Name (First, Middle, Last)										_	3. Time of Death			
Y	Medic	resician/ Medical Chilton Thomas Walker Signal As Facility Name (if not institution, give street and number)  4a. Facility Name (if not institution, give street and number)  4b. City. Town, or Location of Death									0	1:01 P M	1				
4	Examin	ZACITITION TO COMING O								St. Ma		s					
	Funeral				6. Sex 7. / 1 X M 2 □ F		ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da July 2,	rth a <i>y</i> , Ye <i>ar)</i>	9. B	irthpla o <i>untry</i>	ce (State or Foreign	n
	Director		577-46-6 Usual Residence of				73 Yrs.					July 2,	193	7 <u>Vi</u>	rgir	nia	
	yland f sho	ctor	10a. State	10b. County		10c. Cit	y, Town or Lo								10d	. Inside City Limits	
	n 28a notifi	Dire	Maryland 10e. Street and Nun	St. Ma	ry's		Leon	ardto 10f. Zip					10- 0	NA		1 🗆 Yes 2 🛣 No	0
	with the 23a c	Funeral Director			on Beach Ro	ad		101. 2.1		650			10g. Citizen of What Country?  USA				
	death items ner mi	Fun	11. Marital Status		12. Was Deceden	t Ever in U.S	3. 13.	Was Deced	lent of His	spanic Or	igin? (Spec	cify Yes or No-	-	14. Race - Am			
36	after al", or Examir	d by	1 ☐ Never Marri 3X☐ Widowed		If Yes, Give			1 🗆 Yes						Black, Wh Specify.Whi		•	
2-0	hours naturalical E	lete			Year or Dates.		16a. Dece	16a. Decedent's Usual Occupation (Give kind of work done during most of working					16b.	Kind of Busines	s Indus	stry	
21215-0036	thin 72 sne. <b>than "</b>	Completed	Elementary/Seco		College (1-4 o	r 5+)	life. D	O NOT use	retired)	unng mos	st of workir	ig II	G		1 0	1	
d 2	led wil Hygie other ent, th	Be	12 17. Father's Name (First, Middle, Last)					Owner	<u>r</u>	18. Moth	er's Name	(First, Middle	_	mming Poo	I Sa	.Les	_
Maryland	d be fi Mental arked atic ev	유	Horac									h Humph	rie	s			
Man	shoul		19a. Informant's Na					-						or Town, State, Z	·	_	ī
	and 2 Health tem 2;		Daniel Wa 20a. Method of Disp	position				O. Box 214 Leonard				town, I		yland 20650  Location - City or Town, State			_
E E	Page 1 nent of ant: If i		1 🔀 Burial 2 l 4 🗌 Donation	☐ Cremation 5 ☐ Other (S)	3 ☐ Removal from Sta	te C	emetery, crer	natory or o	ther place				1	Leonardtov		, 51010	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral										a1	•			
	42 = 40 O	Н	P.O. 270 Leonardtown, Maryland 2065 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate												-		
	Physician/		shock, or heart failure. List only one cause on each line.										iterval Between				
7	Medical Examiner		resulting in death)	ing in death)  Due to (or as a consequence, f):													
3		ıer	Eequentially list cui if any, leading to im	nditions,	Due to (or as a consequence of):										_		
62	uted Id ansit	amir	cause. Enter Under Cause (Disease or i that initiated events	rlying linlury		MRSA Infection (Sepsis).											
3	cate be executed physician and s the burial-transit	edical Examiner	resulting in death) L		Due to (or a	1	herce of):	-bril	U/2			-					
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+68 ×68	h certif tending r use a	an/N	IF FEMALE: 23b. Was decedent in the past 12 r		23c. If yes, outcom	ne of pregna	ncy Ideath 3 [	Ectopic p	regnancy	,				23d. Date of d	elivery		
h. Bo	requires that the death certific been signed by the attending should be detached for use as	Physician/M	1 Yes 2 Unknown	No	4 ☐ Pregnant 9 ☐ Unknowi	at time of c	leath 5	Other (sp	ecify)				ŀ	Month Day		ay Year	
A. 0.	s that th gned by e deta	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to										to the	cause of death?			
rds,	equires een sig nould b	eted	HIVIAL FIBRIGATES.									1 🗆	Yes 2		No 3 ☐ Probably 4 ☐ Unknown		
auc							ppsy prior to completion of cause of										
<u>8</u>	sician: The la certificate ha rector, page													es 2	□ No	—	
Ϋ́,	hysici nis cer I direc	၉	examiner? 1 Yes 2		Hospital: 1 ☐ Inpa	atient 2 🗷	ER/Outpatier	1t_3 □ DC	Othou	,.			dence	6 ☐ Other (Spe	cify)		
n of	ding P. h. After ti funera	ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time (Month, Day, Year)						Bc. Injury work?	at ∕es 2□	- 1	8d. Describe I	how inju	iry occurred			
isio	Attender deat ector: by the	Certificate:	2 Accident 3 Suicide 4 Homicide	Investiga 6 Could n determin	ot be 28e. Place of Ir			M eet, factory		res 2 L				nd Number or R	ural Ro	ute Number,	
Ö	oital or urs aft rral Dir illed in				building, e	etc. (Specify,						City or Tov		,			()
	re Hosp n 24 ho re Fune pleted f	Medical	(Check 2	Medical Ex	Physician: To the best of aminer: On the basis of Nurse Practioner: To the	examination	and/or invest	tigation, in r	ny opinior	n, death or	ocurred at t	he time, date a	and plac	e, and due to the	cause	(s) and manner state	ed.
	To the Hospital or Attanding Physici within 24 hours after death.  To the Funeral Director: After this cer completed filled in by the funeral director.	-	29b. Signature and t		14///	440			License	number	-	, 400 10 1		ate signed (Mon			_
			rjven	rdel 1	Melly M	· (VL)			100	04	+3		07	, 19/	20	10.	
150			30. Name and addre		ho completed gause of	Lec'n a	23a) (Type, F		40	20	650	r					
	Stat	-	31. Date filed (Month		32. Régis	trar's Signat	ure A	(a. 4)	,							· ·	_
	Registra	T		JUL AA	LUIU KAN	we	14. 14	HULL									

State of Maryland / Department of Health and Mental Hygien? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Agnes Mary Busey Washington July 2010 11, 11:05 P.M /Medical Center 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Thomas More Nursing & Rehabilitation Hvattsville Prince Georges If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Days 1 □ M 2**X** F 84 577-30-8173 Director March 5,1926 Washington, D.C. Usual Besidence of Decedent 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 X Yes 2 □ No Director District of Columbia Washington 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20010 3530 New Hampshire Avenue, N. W. United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married and 2 should be filed within 72 hours afte ealth and Mental Hygiene. n 27 is marked other than "natural", or i Maryland 21215-0036 1 ☐ Yes 2 X No **Black** þ Specify 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Domestic Engineer Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Reginald Busey Ada Mary ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 1940 "U" Place, S.E.; Washington, D.C. 20020 Paul Milton Washington (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State July 20,2010 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cemetery Washington, D.C. Signature of Funeral Service Linensee 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.: 600 Kennedy Street, N.W.; Washington, D.C. 2001 Tandyn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Anterioscienote Candiovascilai **Physician** disease or condition resulting in death) 4 Cavs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence off death certificate be executed and Due to (or as a consequence of) burial-Box 68760, physician Physician/Medical the attending p If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 **X** No Month Day Year 5 ☐ Other (specify) Ö the 9 I Unknown <u>~</u> ģ The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed failure Ventilater Dependent 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has autopsy performe Gencons certificate 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 ☑No Certification: To this After thi funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: completely filled in by the f 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Medical ধ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 420781 Queensbury Rd Hyattsville MD 20181 31. Date filed (Month, Day, Year) 32/Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUL 1 5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 9, 2010 Josephine Woods 1419 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Prince George's Hospital Cheverly Social Security Number Year If Under 24 Hrs. 8. Date of Birth If Under 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🏝 F Days Hours Min. Dec. 19, Year) 920 89 North Carolina Director 579-36-4003 Usual Residence of Decedent 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 ☐ No Maryland Prince George's District Heights 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 6708 Foster Street 20747 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc "natural", or 1 Never Married 2 Married ð Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: African Completed 3 Divorced Year or Dates American the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12th Master Chef Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tom Woods Ludie Smyn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles B. Woods/ Grandson 6708 Foster Street District Heights, Md. 20747 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State July 19, ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland Lincoln Cemetery 2010 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Si viature of Funeral Service License 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resciratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🗷 No Month Day sate has been signed by the a page 2 should be detached it g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Heart 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? To the Hospital or Attending Priyswam within 24 hours after death.

To the Funeral Director: After this certificate this certificate 2 X No 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: Certificate: To 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 1 Natural 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 **Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and the of certifier

Registrar DHMH 17 Rev 7/2009

State

Hospita

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

3001

32. Registrar's Signature

Griffin Davis,

JUL 1 5 2010

31. Date filed (Month, Day, Year)

D63688

Cheverly, MA

29d. Date signed (Month, Day, Year)

Please Type or Print în Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ JULY 7, 2010 0253 NTHONY CLIFTON WILLIAMS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Washington, †**x**□ M 2 □ F 9/28/1940 Director 69 <u>579-42-5210</u> Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 🖾 Yes 2 🗌 No DC Washington 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 20011 United States 4860 Fort Totten Drive NE Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Never Married 2 🔀 Married Yes, Give 2 🗌 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Black Year or Dates Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) t of Health and Mental Hygiene. If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Military Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Eugene Theodore Williams Clarice Byrd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarice Williams / Mother 4310 Elizabeth Drive Waldorf, Maryland 20601 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Washington National 7/15/2010 Signature of Funeral Service 22. Name and Address of Facility Alexander S. Pope Funeral Home M 2617 Penn. Ave. SE Washington, DC 20020 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially flet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been stoned by the effection of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the co Exami that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for use as the burial Diasculer Discaso Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 9 Unknown Part II. **Other significant condit<del>ions con</del>tributing to death but not resulting in the underlying cause given in Part I**. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No completed filled in by the funeral director, 25. Was case referrento medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Li No 1 PInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

only one) 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)
JUL 1 5 2010

DHMH 17 Rev 7/2009

person who completed cause of death (Item 23a) (Type, Print)

29c. License number

867

29d. Date signed (Month, Day, Year)

ROCKVILLE MA 20852

			AMEND 10f & State Registrar 19a WCHD/SH	State of Maryl 7/21/10 per					Mental Hy	giene Reg. No.	010	23751	
	Physici /Medi		1. Decedent's Name (First, Middle, Last, Butler D	onald WALLA	CE				2. Date of De Month July 1		10 Year	3. Time of Death 10:15рм	
ر		Examiner  4a. Facility Name (If not institution, give street and number)  Julia Manor						ocation of De	ath	4c. County of Death Washington			
	Funeral Director		443-14-3727	7. Age (in )	yrs. last birthday) 87 Yrs.			f Under 24 H Hours Mi		1923	9. Birth Ok La	nplace (State or Foreign untry) anoma	
	Maryland -f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Washingt		City, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 No	
	th with the 23a or 28a ist be notif	Funeral Director	10e. Street and Number 1541 Crest View A	venue		10f. Zip	Code -217	<del>42</del> 217	40		on of What Co	untry?	
980	be filed within 72 hours after death with the Maryland ital Hygiene.  d other than "natural", or Iteme 23e or 28e-f show event, the Madiral Examiner must be notified at	by Funer	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 X Yes 2 □ No 1 If Yes, Give Year or Dates: 1	943-	Was Decede If Yes, speci 1 Yes 2		anic Origin? Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		4. Race - Amer Black, White Specify:Ame		
21215-0036	id within 72 h giene. er then "netu , the Medical	Completed by	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	(Give kind of w			ent's Usual Occupation ind of work done during most of working O NOT use retired) tologist				ndustry 7ed	
Maryland	S should be filed within and Mental Hygiene. ie marked other than aumatic event, me M.	To Be (	17. Father's Name (First, Middle, Last)  Rosco	Wallace			18		ame (First, Middle ry Lassi		Surname)		
-	ges 1 and of Health if item 27 or other tr		19a. Informant's Name/Relationship (Ty  Beverly L. Wallace  20a. Method of Disposition  1 □ Burial 2 ☼ Cremation 3 □ P	Beverly J Wallace	b. Place of Disponentery, cree	Crest	View	w Aven	Date	20c. Loca	n, Mary	1and 21742 Fown, State	
Baltimore,	permit. Pag Department important: any injury once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens			2. Name and	d Address	of Facility	Minnic	h Fun	eral Ho	, Maryland ome ryland 21740	
-	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onsel and Death disease or condition resulting in death)  Due to (or as a consequence of):  Contonately  Due to or as a consequence of):  Fathstudation  Years  Years									Approximate Interval Between Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death Onsel and Death O	
68760,	licate be executed physicien and s the burial-transit	dical	that initiated events resulting in death) Last	Duy to (or as a con	sequence of):	Va	aci	ular	Dis			Years.	
.O. Box	that the death certific led by the attending p deteched for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3	⊒Ectopic pre ☐ Other (spe				23	3d. Date of deli Month	very Day Year	
Ω.	es Deg	by	Part II. Other significant conditions cor	ntributing to death but not	resulting in the u	nderlying ca	use given	ìn Part I.	23e. Did		/	the cause of death?	
of Vital Records,	The law ete has b page 2 s	Completed	Gule	c s	•				24a. Was auto perfe 1 Yes		24b. Were au prior to death?	topsy findings available completion of cause of	
<b>X</b> ita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:			Othor		eath (Check only				
on of	Attending Physic death.  ector: After this by the funeral di	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient :  28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time of Injury		C. Injury at Work?		Home 5 Resi			ify)	
Division	5 # 등 드	Certification;	3 Suicide 6 Could not be determined	At home, farm, str ecify)	a, farm, street, factory, office 28f. Loc					cation (Street and Number or Rural Route Number, y or Town, State)			
	the Hospitel hin 24 hours a the Funeral I hpletely filled	edical	29a. Certifier 1 Certifying Physical Check duly 2 Medical Examin	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred a vestigation,	it the time, in my opin	date and pla ion, death oc	ce, and due to the curred at the time,	cause(s) a date and p	ind manner as place, and due	stated. to the cause(s)	
	To the within To the comple	M	29b. Signature and title of certifier				License n		1 -		signed (Month		
غ	112+1		30. Name and address of person who co	ompleted cause of death (		Print) O	ulu	etau	1. , A +	FAG.	MO 2	1740.	
24]	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar's S	gnature	and	,						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20 Pay 2010  $J_{\mathbf{u}}^{\text{Month}}$ Charlene Young 1242 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. . Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Feb. 14, Year) 1947 1 M 2 X F Months Days Hours Maryland Director 219-46-1329 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Washington Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 221 Nottingham Road 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ğ 1 ☐ Yes 2 🗓 No If Yes, Give 72 hours after 1 ☐ Yes 2 💢 No Specify. White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2121 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) filed within Registered Nurse Nursing Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Morley Germroth Phyllis Titlow eq plnous 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Ronald G. Herbert / Companion 221 Nottingham Road, Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 7/26/2010 Rest Haven Cemetery Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Rest Haven Funeral Chapel S. Men 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or comp 1 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RESPIRATORY FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner HEART FAILURE CONGESTIVE 5 squentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit The law requires that the death certificate be executed PNEUMONIA Due to (or as a consequence of) resulting in death) Last Physician/Medical END STAGE RENAL DISEASE IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Day 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ڇ ISCHEMIC ACUTE TUBULAR NECROSIS Be Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of DIABETES MELLITUS las autopsy performed' death? After this certificate HYPERTENSION 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Gantino 20 2010 41162 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GERMANTOWN MD 20874 19529 DRIVE VINU GANTI DOCTORS 31. Date filed (Month, Day, Year) 32. Regis

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State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#17perFH, G905, 7/30/2010, WS
State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Wilma Glenn Arnold July 29, 2010 6:15 A M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Middle River 63 Chandelle Road Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Months Min. 1 □ M 2 🕅 F 412 28 5632 101 05/18/1909 Tennessee Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 XNo Maryland Baltimore Middle River 10e. Street and Number 10g. Citizen of What Country? 63 Chandelle Road 21220 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 XNo Specify: Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Health Care Assistant Nursing Center 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Ward Susan Caroline Arnold 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hathaway-Percy Funeral Home 101 E. F Street Elizabethon, TN 37343 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3X Removal from State Carter County Union Baptist Ch Cem. 08/02/2010 Ponation 5 ☐ Other (Specify) Tennessee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Slana ire of 1407 Old Eastern Avenue Essex Maryland 21221 Approximate Interval Between Onset and Death Enter the disease. complications that caused the death-inly one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 hoc or heart failure. List Imm diate Cause (F disease of condition resulting in death) Cause (Final Due to (or a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease o, injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? X Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

/Medical **Examiner** or Attending Physician: The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records,

as attending r asn for ģ page 2 s director, this After 24 hours after death. the filled in by the Hospital completely within 2.

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

items 23a

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Health and Mental Hygiene.

permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trau

**Physician** 

sician and burial-trans

physician s the burial

within 72 hours after death

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

Director

Funeral

À

Completed

Be

Examine

Physician/Medical

Completed by

Be

Medical Certification: To

18

Registrar

Charles Boice, M.D., 9103 Franklin Sqaure Drive, Baltimore, Maryland 21237-3998 31. Date filed (Month, Day, Year)

29a, Certifier

(Check only

29b. Signature and title of certifier

32. Registrar's Signatur

Olles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ 7:32 P M ARMON 2010 u 2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ltimore N/Aattimore Ba ta If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 **X** M 2 □ F Hours 06917, 1911921 Country) PA 89 **Director** 183-14-2182 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 28a-f 1X☐ Yes 2 ☐ No BALTIMORE N/A MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or edical Examiner must be Funeral 21209 USA 6350 RED CEDAR PLACE, #308 八かぬれ、Jack Baltimore, Maryland 21215-0036 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced WHITE Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) OWNER RETAIL Be permit. Page 1 and 2 should be file.
Department of Health and Mental Hv.
Important: If item 27 is marany injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ GREENSPAN DAVID ARMON MINNIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3021 FALLSTAFF ROAD, #304, BALTIMORE, MD CAROL ARMON/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 7/29/2010 BALTIMORE, MD BNAI ISRAEL CONG. 4 ☐ Donation 5 ☐ Other (Specify) gnature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ ntra cra nia disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed erotir that initiated events resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ kidney disease, previous 1 ☐ Yes 2 Yes 3 ☐ Probably 4 ☐ Unknown Completed Congestive heart failure 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 death? 1 ☐ Yes 2 ☐ No this certificate Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES-000 27 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) of Baltimore MD Sinai 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Day 2010 Year Physician/ Bloedorn Pollyanna Conway 26 11:42 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rethesda 5304 Wriley Rd. If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 □ M 2 🛛 F Months Ohio 92 Director 17,1917 319-18-4976 Nov. Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No MD Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20816 5304 Wriley Rd. United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No 1 Never Married 2 Married 72 hours after <u></u> Yes 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White Specify: 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Wholesale Pet Food Self Employed and Mental Hygie is marked other permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, the Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Pease Jessica John Conway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlene E. Bloedorn/ Daughter 4804 Broad Brook Dr., Bethesda, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 8/3/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory ! ²² Name and Address of Facility Rapp Funeral and Cremation Services 21. Signature of Funeral Service Licenses Stophe Lollin Ave., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ MULTI, disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and s the burial-transit Cause (Disease or iinjury that initiated events that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 iding p IF FEMALE: nse 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy jo Month Day Year 4 Pregnant at time of death 9 Unknown signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed death? 2 X N ☐ Yes 2☐ No the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 MResidence 6 Other (Specify) 1 Yes 2 M No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral to 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of eertific 29d. Date signed (Month, Day, Year) July 27, 2010 D26259 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

State Registrar KAUFMAN M.D.

31. Date filed (Month, Day, Year)

8219 Wisconsin Ave., #103, Bethesda, MD

20814

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 23756 State of Maryland / Department of Health and Mental Hygiene

		- For State Certificate	e of Death	Reg.	No.					
Physicia 'ical Examir	n/	Registrar 1. Decedent's Name (First, Middle,Last) Howard Frederick Benson		2. Date of Death Month D July 23, 201	ay Year 0	3. Time of Death 1508 hrs				
		4a. Facility Name (if not institution, give street and number) 3570 Hance Road	4b. City, Town, or Location of Death Port Republic							
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 20-56-1658 1 M 2 F 59	MM/DD/YYYY) 9. Birth Foreign Cou	nplace (State or not not not not not not not not not not						
,		Usual Residence of Decedent  10a State 10b County 10c. City, Town or I	ocation			10d. Inside City Limits				
w any		Tou. Oldie	Republic			1 Yes 2 No				
Maryland 28a-f show d at once.	ģ	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Coun	try?				
th the Maryland 23a or 28a-f sho notified at once.	Dire	3570 Hance Road	20676		USA					
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.  Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	3. Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puerto  1 Yes 2 No specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ White, etc. Specify: W	an Indian, Black,				
urs aft tural'	좕	15 Decedent's Education (Specify only highest grade completed) 16a. Dec	cedent's Usual Occupation (Give kind of		6b. Kind of Business/Ir					
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21215-0036 buld be filed within 7 Mental Hygiene. marked other than c event, the Medica						Zip Code)				
e, MD 21215-0036 I and 2 should be filed within 72 Health and Mental Hygiene. item 27 is marked other than r traumatic event, the Medical	-	Bill Bonson, Bon	Mailing Address (Street and Number or 26 Peverly Run		ingdon, l					
Baltimore, permit. Pages I an Department of Heal Important: If iten injury or other tra		4 Duriet 2 Compation 2 Removal from State crematory	or other place)  apeake Crem.	1117 20 1	Beltsvil.					
Balti permit. Departm Import injury		21 (Signature of Funeral Service Licensee - 0/4/3	Cremation Fand F 8717 Green Past	uneral ures Dr	Alternative Balt	ives , MD 2128				
Physician	+	23a. Part I. Inter the disease, or complications that caused the death. Do not e				Approximate Interval Between Onset and				
/Medical. Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovasculate Due to (or as a consequence of):	Disease			Death				
	_	Sequentially list conditions,  b.  Due to (or as a consequence of):								
	mine	cause. Enter Underlying Cause (Disease or injury that initiated								
uted Id ansit	Examiner	events resulting in death) Last Due to (or as a consequence of):								
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3760, ificate be g physici s the buri		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregr	nancy	23d. Date of delivery  Month	y Day Year				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed writhin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	/sician/	Pregnant at time of death 5	Other (Specify)							
b. Bc the dear	Phy	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?				
Division of Vital Records, P.O. tall or Attending Physician: The law requires that the staff ceath.  **Al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	آھ			1 Yes	2 ✓ No 3 Prob	pably 4 Unknown				
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II R	ö	25. Was case referred to medical	26.Place of Death (Chec							
Vita hysicia direci	8	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outp			esidence 6 🗸 Other	Scene				
ing Ph	Ë	(Month, Day, Year)	ne of Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred					
sion ttend: death. ctor: y the f	atio	2 Accident Investigation	1 Yes 2 No	204 Lacation (St	root and Number of Pu	ral Route Number, City				
JVIS I or A after din b	Certification:	Suicide Could not be	n, street, factory, office building, etc.	or Town, Sta		irai Rodie Number, City				
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.    1										
F. ≥ 5 0	Š	29b, Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)					
		Mergera The Shell	O.C.M.E.		July 24, 2010					
6V		30. Name and address of person who completed cause of death (Item 23a)	11 Penn Street, Baltimore, MI	21201						
) "		22 Parties Signature	11 Penn Street, Daltimore, ML							
St Regis	tate	1111 0 0 0040   20 11	6-00							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien \( \text{\text{\$\cappa}} \) \( \text{\$\cappa} \)

			Please Type or Print in E State of Maryland L_State	d / Depa	artment of He	alth and Men			23757	
			Registrar	Cer	tificate of De		Reg. N	No.		
	Physicia Medic		1. Decedent's Name (First, Middle, Last)  Robert David Baker			, N	ate of Death	7, 2010	3. Time of Death 10: 23 P M	
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Lo	cation of Death	_	lc. County of Death		
	4		Upper Chesapeake Medical Cente 5. Social Security Number   6. Sex   7. Age (In yrs. la		Bel Air	f Under 24 Hrs. 8. D	ate of Birth	Harford	nplace (State or Foreign	
	Funeral Director		234-34-1787 1™ № 2□F 85	Yrs.			Month, Pay, Year	1925 Wes	t Virginia	
10.0	and show 1 at	ior	Usual Residence of Decedent         10a. State         10b. County         10c. City	, Town or Loc	cation				10d. Inside City Limits	
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	th the 3a or t be n	a	10e. Street and Number		10f. Zip Code			Citizen of What Cou	intry?	
	ath wi	mel	1600 Eva Avenue  11. Marital Status 12. Was Decedent Ever in U.S	. I 13. V	21085 Vas Decedent of Hispa	anic Origin? (Specify Y		JSA 14. Race - Amer		
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Narried 1 Never Married 2 Narried 3 Widowed 4 Divorced Year or Dates.		Yes, specify Cuban, I	anic Origin? (Specify Y Mexican, Puerto Rican Specify:	, etc.)	Black, White Specify: Whi	, etc.	
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1-2010			23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not ente	er the mode of dying, s	such as cardiac or resp	oiratory arrest,		Approximate Interval Between	
8	Physician/	10	Immediate Cause (Final disease or condition	de	um d	uffic	ile	2	Onset and Death	
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2	oe executed ician and burial-transi	calE	resulting in death) Last Due to (or as a consequ	ence of):						
) 2 2 2 2 2 3 2	cate b physic	edic	d			<u>-</u>				
(L) / (1)	eath certificate be executed attending physician and for use as the burial-transit	Z/W	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Feta		Ectopic pregnancy			23d. Date of deli	ivery	
491 Box	Attending Physician: The law requires that the death certificate or death.  sctor. After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the	Physician/Medi	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  1 ☐ Ves 2 ☐ No 9 ☐ Unknown		Other (specify)			Month	Day Year	
90	requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resu	ulting in the u	inderlying cause given	in Part I.	23e. Did tobacc	o use contribute to	the cause of death?	
$\sim 10800 486$ Vital Records, P.O	uires t n sign ald be	Completed by	Multiple myeloma	, Le	ukenia		1 🗌 Yes	2 <b>P</b> √00 3 □ Pr	obably 4 🗆 Unknown	
SOC Society	aw req as bee 2 sho	ıplet	Colon Carces				24a. Was an autopsy	prior to o	opsy findings available completion of cause of	
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ital	sician: The law r certificate has t lirector, page 2 s	Be c	25. Was case referred to a lexaminer? 1 — Yes 2 No Hospital:		Other:	e of Death (Check only		0 7 00 00	×.1	
√ jo	g Physer this eral di	e: To	27. Manner of Death 28a. Date of injury	28b. Time of	28c. Injury at	4 Nursing Home t 28d.	5   Residence  Describe how in		<u>TY)</u>	
76	ending sath. or: Afte he fun	ficat	2 Accident Investigation	injury	M 1 ☐ Ye	s 2 🗆 No				
Sisi Visi		Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At ho building, etc. (Specify,	me, farm, str	eet, factory, office	28f. L	ocation (Street City or Town, Sta	and Number or Rur ate)	al Route Number,	
10	the Hospital or thin 24 hours afte the Funeral Dir mpleted filled in		29a. Certifier 1 Certifying Physician: To the best of my knowle	edge, death	occured at the time, da	ate and place, and due	e to the cause(s)	and manner as sta	ted.	
	To the Hospita within 24 hours To the Funeral completed filled	Medical								
+_	Noith to the		29b. Signature and title of certifier		29c. License n		29d. I	Date signed (Month	, Day, Year)	
2	201		CO Name and address of	230) /5: '		400er Cl	410	and of	> 2010	
90	Mx A		30. Name and address of person with completed cause of death (Item	LD (Type, F	300	( Aic	Mara	land		
(X	Sta		31. Date filed (Month) Day, Year) 31. Registrar's Signat	ure				)		
	Registr	ar	JUL 3 0 2010 Cenur A. 10	u Kal						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death dward BOYEV Month U(Y Physician/ 23ay 35 PM wvence 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Luch Ravan Community Living Center Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 🖾 M 2 🗆 F Months Hours Jan 18, 1950Maryland Director 60 217-54-4307 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 XYes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 USA 7809 W. Cunningham Drive #E within 72 hours after death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces? 1 Yes 2 No 1968-If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 white 1970 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) home improvement painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Evelyn Wilkerson Lawrence E. Beyer Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Ebbert - step sister 304 E. Belcrest Road; Bel Air, Maryland 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5X Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 21. Signatur Funeral Service Licensee 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Wer Onset and Death Immediate Cause (Final Pnysician/ 0515 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner patitis Sequentially list conditions, in any, leading to immediate cause. Enter Underlying and I-transit Exam Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a d be detached f Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed death? 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 12 No Other: HUSPICE 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ieral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🖾 Natural work?
1 Yes 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Battimove 21218 Luch Raven Bonlevard. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

George 31. Date filed (Month, Day, Year) 3900

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $\mathtt{July}^{\mathsf{Month}}$ Physician/ 2010 Year Coriell Betsv June 11:45P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Glen Meadows Glen Arm If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** CountryOhio 1 🗆 M 2 🍑 Days Hours 06.24.1924 294.14.9351 86 Director Usual Residence of Decedent 23a or 28a-f show 10h County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or pother traumatic event, the Medical Examiner must be notified at 10a. State Director Baltimore 1 🗆 Yes 2 🚉 📉 MD Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11630 Glen Arm Road 21057 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11 Marital Status Armed Forces2
1 ☐ Yes 2 ☐ No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: If Yes Give 3 ₩idowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 7. Father's Name (First, Middle, Last)
Elmer C. Pierce 18. Mother's Name (First, Middle, Maiden Surname) Harriette Parsons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Kerns/Daughter 2657 Beckleysville Rd. Manchester, MD 21102 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Chesapeake Crem. 07.30.10 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, PA Signature of Funeral Service Licenses Balto. MD 21286 Green Pastures Dr 23a. Part 1. Etter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Design Immediate Cause (Final disease or condition Physician/ Adeno Conc Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlar-transit completed filled in by the funeral director, page 2 should be detached for use as the burlar-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 1 Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown cate has been siç ; page 2 should b Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? Yes 2 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury work?
1 Yes 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier 🕍 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Occurred In the Dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of confier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)
RAMANA GOPDLAN MD 28 ROW, NG (ROM ROADS #159 B) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23760 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2:40^MP Anna Margaret Calla Julv 28 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brookfield Manor Resident Care Carroll Keymar If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 11,1923 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. 1 □ M 2 🛛 F Months Hours Country) PA 86 Director 188-14-9069 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2X No Director MD Carroll Keymar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 5800 Middleburg Rd. 21757 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 1 ☐Yes 2 X If Yes, Give Year or Dates: 10 1 Never Married 2 Married 2 🕅 No Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify 2 Specify: White 3 ☑ Widowed 4 ☐ Divorced r than "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry alth and Mental Hygiene. 27 is marked other than " r traumatic event, the Me Elementary/Secondary (0-12) 12 College (1-4or 5+) Cashier Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Joseph A. McKittrick Sarah McGowan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important; If item 27 is any injury or other trau once. Cynthia Calla/daughter New Market, MD 21774 6118 Samuel Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) All County Cremation 7/29/10 Sykesville, MD 21. Signature Fineral Service Litensee 22. Name and Address of Facility Hartzler Funeral Home New Windsor, MD 21776 310 Church St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dementia Alzheimer's type vears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Principle 1 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in the physician and 5 in burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the attending philorope as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Recurrent transient cerebral ischemia 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 X No 1 ☐ Yes 2  $\square$  No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Living 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

J.H.

Caricofe

31. Date filed (Month, Day, Year)

295 Bucher John Rd

32. Registrar's Signature

30. Name and address of person who complet it cause of death (Item 23a) (Type, Print)

D0000906

7/28/2010

Union Bridge, MD 21791

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month > 2 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, BOL trmore boot Sumaritar Hospita If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 - M 2 X Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. **Funeral Director** ems 23a or 28a-f sh r must be notified a 1 Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items edica Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 🗌 Widowed 4 🔲 Divorced Year or Dates 27 is marked other than "natural traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) ne (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) မ 19a. Informant's Name/Relationship (Type, Print) (husband) 19b. Mailing Address (Street and Number Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location -City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 21. Signature Fineral Service Licensee Name and Address of Fa Hom 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Respiration disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner SEDSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending humanian and To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events bil 2no lumbria Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes No Month Day Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Maprier of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1har 2010 W) D RES-000 128 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven Blvd. Baltimore 5601 Loch Abhireet

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Migdle, Last) 2. Date of Death **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 🔀 M 2 🗆 F 76 233-48-3048 1933 Director Dec. 1, Weston, W Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show ä 1 X Yes 2 □ No WV Kanawha Director St. Albans must be notified 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ō Pages 1 and 2 should be filed within 72 hours after death with 500 Weimer Avenue 25177 items 23a United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼ No If Yes, Give 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 🔀 Married , o Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White þ 3 Widowed 4 Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Engineering Elementary/Secondary (0-12) College (1-4 or 5+) Fire Protection Engineer the 12 other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ith and Mental F 27 is marked of traumatic ever Howard Thomas Cress, Sr Clara Elizabeth Fultineer ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 500 Weimer Ave. St. Albans, W 25177 Jeanne L. Cress/ Wife 27 Department of Health Important: If item 27 any Injury or other the once. 20c. Location - City or Town, State 20a. Method of Disposition 1 Donation 5 Officers (Section 1) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date August 1, Richwood, Chio Donation 5 Other (Specify) 2010 Claybourne Cem. 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services 21. Signature of Funeral Service Licens 8800 Harford Rd. Parkville, MD 21234 23a. Pan 1. Entertitle disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresponds to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the con Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner KENA CELL CANGER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing in death). Examine Due to (or as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-trans Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1  $\square$  Live birth 2  $\square$  Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ρλ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq 4 Unknown 2 No 3 Probably 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 2 🗌 No 1 🗌 Yes Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes Certification: To 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After completely filled in by the fune 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of perting

State Registrar 30. Name and address

31. Date filed (Month

DHMH 17 Rev 1/2001

600 North Wolfe St, Baltimore, MD, 21287

s of person who completed cause of death (frem 23a) (Type, Print)

32. Registrar's igna

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July 2010 Charlotte Mae Cohen 1:00A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Baltimore Timonium 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Feb. 6, 1923 Davs 1 M 2 TyF 87 218-12-8833 Yrs Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Director PA Fawn Grove 1 Yes 2XXNo York 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 417 Salt Lake Road 17321 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? 1 🗌 Yes 2**X X**Vo Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: White Specify: Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) 12 Hairdresser Hygiene Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Bowers Mary Elizabeth Hines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 417 Salt Lake Road, Fawn Grove, PA 17321 Barbara Quinn - Daughter Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Evans Funeral Chapel and
Cremation Services 1 Durial 2 X Cremation 3 Removal from State 7/30/2010 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services — Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ CONGESTIVE HEART FAILURE Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 1 ☐ Yes 2 10 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury X Natural 5 Pending 1 Yes Investigation Accident 24 hours after deat Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of cert 29c. License number signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar JACKIE JONES,

CRNP

00:1

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #16b,20a-c&22 Per FH G906 8/05/2010 JH State of Maryland / Department of Health and Mental Hygiene Reg. No 20 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2715 11.45 AM WINSTON ع COCHRAN JULY 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George S Laurel Rehal. Patrixent River Health and 9. Birthplace (State or Foreign Michigan 8. Date of Birth (Month, Day, Year) Jan 19, 1953 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number **Funeral** Min. Months Days Hours 1**₹** M 2□ F 57 369-58-8435 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Mexical Eventhat nust be notified at 1 ☐ Yes 2 No Laurel Prince Georges MD Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" --- any injury or other traumatic event USA 20708 11329 Laurel Walk Drive Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married Specify: black 1 ☐ Yes 2 🖾 No Specify: δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry The District of Columbia 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Government College (1-4or 5+) social worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Cochran Joyce Foster ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11329 Laurel Walk Drive; Laurel, Maryland 20708 Gail Gibson - friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
West Arundel Crematory July Day 1, 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 2010 Odenton, MD 4 □ Donation 5 € Other (Specify) in State 22 Name of ddress Facility tate Anatom: Poard Domaidson Funeral Home, A.A.
313 Talbott Avenue, Laurel, Maryland gnature of The Hall 5 Director MD 21201 20707 KIL 23a, Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) years ementia **Physician** /Medical Due to (or as a consequence of): Examiner Years accident Cerebrorancular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ahure autopsy performed? 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 53411 2715 J wery MD 14 300 Gallant For 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Shesadni

31. Date filed (Month, Day, Year) ----

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760.

bark

Bowle

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 | 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Month 7 3:01 PM 2010 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Center Battimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🖾 F Davs Hours (Month, Bay, Year) 30 Maryland **Director** 218-26-2497 80 Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location 10d Inside City Limits Examiner must be notified at Director Harford MT Abingdon 1 Yes 2X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 21009 USA 511 Nanticoke Court death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 within 72 hours after Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", Completed 3 Widowed 4 X Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) iewelry buyer iewe1s injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Jerome Getz Carrie Carlisle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Dianne Lybolt - daughter 511 Nanticoke Court; Abingdon, Maryland 21009 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Si natur of Funeral Sauce License Ronald S 22. Name and Address of Facility State Anatomy Board any ector 655 W. Baltimore Street; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph. sician/ ardiac years Ischemic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed -tran Due to (or as a consequence of): burialphysician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Day Month Year Pregnant at time of death signed by the a Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗆 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed has been signed to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second to the second 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy director, page performed certificate Yes 2 N the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 👿 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ᅆ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1659696193 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) University of Maryland Medical Center, 22 S Greene St, Baltimere, Md 21201

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 23766 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Month Physician/ P M Ruth Virginia Coffey July 28, 5:05 Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore 1315 Chesaco Ave. Apt. 301 Roseda1e 8. Date of Birth
(Month, Day, Yea
Dec. 25, Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔽 F Hours Maryland Director 217-16-8694 86 1923 Usual Residence of Decedent 23a or 28a-f show 10b. County the Maryland at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 🗌 Yes 2 💢 No MD Ba1timore Roseda1e 10e. Street and Numbe 10g. Citizen of What Country? Funeral "natural", or items 23 U.S.A. 21237 1313 Chesaco Ave. Apt. 301 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 No 21215-0036 1 ∐ Yes If Yes, Give 1 ☐ Yes 2X No Specify: White Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ pe G1adys Thornton unknown <u>unknown</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 8637 Saxon Circle, Nottingham, MD 21236 <u> Carol Greenspun / Daughter</u> altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 7/31/10 Mt. Airy, MD Pine Grove Cem. 21. Signature Fur eral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. #1605 Reisterstown Rd. Owings Mi**11**s, MD2111 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Compared at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day the 9 Unknown 9 Unknown signed by the Part II A her significant conditions contributing to death but not resulting in the y derlying cause given in Part to 23e. Did tobacco use contribute to the cause of death? þ Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an s certificate has the performe 2 No Yes 2 1 Tes or Attending Physician: of Vital 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 40 1 🗌 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medica 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the bass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurs Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature ar title of certifier 30. Name and address of person who completes cause of death (tem 23a) (Type, Print) Baltimore, MD 21236 MD 7602 Belair Rd. Michael Zang, 31. Date filed (Month, Day, Year) State 30 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 23767 State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Chelton Doris Μ. Tuly 2010 Medical 2 - 40 4a. Facility Name (if not institution, give street and number)
Greater Baltimore Medical **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Center Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day May 10 9. Birthplace (State or Foreign Funeral 1 □ M 2**X** F Year 1928 217-22-9361 Mary and 82 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Baltimore Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 146 Stanmore Road 21212 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. 1 Never Married 2 X Married Completed by 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Wallace Edward Trainor Ida Sachs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21212 Stanmore Road Baltimore, Maryland Keith Chelton/ Husband 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Mem. Gans. 8/2/2010 Timonium, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Sancticense 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician. disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to ministrate cause. Enter Underlying Cause (Disease or iinjury Alle to for be a consequence Exami that the death certificate be executed the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) 9 Unknown P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires the At hours after death.

Funeral Director: After this certificate has been sign sted filled in by the funeral director, page 2 should be better that the funeral director, page 2 should be Division of Vital Records, 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Inpatient ER/Outpatient 3 DOA Manner 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: Death 28b. Time of 28d. Describe how injury occurred ■ Natural 5 Pending 1 Yes Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar re and title of certifier

31. Date filed (Month, Day, Year)

ause of death (Item 23a) (Type, Print) N. Ch.-lest.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Year Physician/ Augustus Dorsey 1:16A.M 26 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death  ${\tt Towson}$ **Examiner** 4c.Banytinhore Gilchrist Center Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign 8. Date of Birth Funeral 1 🔀 M 2 🗆 F Days Hours Min. (Month, Day, Year Country) Maryland 69 216-36-2295 Director Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Baltimore Marylan¢ 1√ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 Funeral USA 5507 Stonington Avenue Page 1 and 2 should be filed within 72 hours area www.trnent of Health and Mental Hyglene.
rtant: If item 27 is marked other than "natural", or iten Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 SpeBlack 1 Yes 2 No Specify: 3 🗌 Widowed 4 😾 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Health Commissioner Be 18. Mother's Name (First, Middle, Maiden Surname)
Carrie Marie Thomas 17. Father's Name (First, Middle, Last) Carrie Marie Elias Albert Dorsey 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number, or Rural Route Number, City or Jown State 7102905)

Noe Ave Baltimore, Mary Land 4909 Catherine Dorsey/Sister 20a. Method of Disposition cemetery, crematory or other place)
Crest Lawn Cemetery 7/31/10 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot Marriottsville, MD 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, MD 21215 Signature of Buneral Service Linux 11e 23a. Part i. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ van Chartic mon The disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last physician and s the burial-transit Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the burn Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 4 Pregnant at time of death Month Day Year Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed 24b, Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No |요 4 Nursing Home 5 Residence 6 Other (Specify) Wife 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2010 Physician/ Month WILLIAM DUPREE 5 :55AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** TOHNS HOPKINS BAYVEEW MEDICAL CENTE BALTIMORE If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Hours Min 0971871971 Mary land Director 212-82-8216 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at with the Maryland Director 1 Yes 2 KNo Middle River Maryland Baltimore 10e. Street and Number 10f, Zip Code 10q. Citizen of What Country? Funeral 4060 Rustico Road 21220 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status Race - American Indian. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. δ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: 3 ☐ Widowed 4 🖾 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene.
7 is marked other than "I Elementary/Seconday (0-12) College (1-4 or 5+) Delivery Driver other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Frank Dupree, Jr. Gwendolyn Middleton permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5532 McCormick Avenue, Baltimore, Maryland 21206 Christine Bivens (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State Bayview Crematory, Inc.07/29/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A Signature of Eugeral Service Licenses <u>Old Eastern Avenue, Essex, </u> Maryland 21221 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Pnysician/ di ease or condition r sulting in death) Medical Due to (or as a consequence of): Examiner Stroke Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Month Pregnant at time of death 2 No been signed by the should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of sate has page 2 s autopsy death' within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 2 🗆 No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No မ 1 🗌 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury work? 1 🗌 Yes 2 🗌 No 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 28, 2010 RES-000 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21224 BALTIMORE, MD 4940 EASTERN AVENUE PAYAM MOHASSEL M.D

DHMH 17 Rev 7/2009

State Registrar 32. Registra Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #18tate of Margiand / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Physician/ 6:45P 2010 rear Leona C. Dolby 28 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Brinton Woods Nursing Sykesville Carroll 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 3 – 1 7 – 1 9 1 5 Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🕱 F Director 213-03-3747 95 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director Carroll Westminster MD 1 🗆 Yes 2 🖺 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 Completed by Funeral 507 High Acre Dr. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: white 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Real Estate Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First N.P. M.C. Surname) 2 Louis B. Bailey Anna M. Dickerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June C. Griffin-daughter 9317 Pan Ridge Rd., Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cem. 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8-7-2010 Baltimore, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home Thomas 21157 Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the migre of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final rundlo MSTERTINE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) use as the burial-tran ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant : 9 Unknown Pregnant at time of death Other (specify) 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed After this certificate has 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Be 1 Yes 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deatle Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: Jodge Best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29c, License number 29d. Date signed (Month, Day, Year) eel 10f06 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TURNES, ND Busmoss Center 32. Registrar's Sig

Registrar

Pie	ase Type or F									
For State	State of	Marylan	d / Depa Cer	irtment of F	Health Death	and N	/lental Hy			0 23771
	Registrar Certificate of Death Reg. No.						3. Time of Death			
m/ Mallie A. Ea	son						July 2	27,	^{ay} 2010 ^{Yea}	8:30A M
4a. Facility Name (if not institution	n, give street and number	er)		4b. City, Town, or	r Location	of Death	•	<u> </u>	c. County of D	
Sunrise of R				Rockvi		0411			Montgon	
5. Social Security Number 244-09-4076	6. Sex 1 \( \text{M} \) 2 \( \text{F} \) F	. Age (In yrs. la		If Under 1 Year Months Days	if Under Hours	Min.	8. Date of Bit (Month, Da June	rth ay, Year).	1014 N	Birthplace (State or Foreign Country) North Carolin
Usual Residence of Decedent					June	.4,	1914  1	With Calotti		
10a. State 10b. Count 10c. Street and Number 1017 Kennon Co	у	10c. City	y, Town or Loc	ation						10d. Inside City Limits
Maryland Mont	gomery	Roc	kville							1 X Yes 2 □ No
10e. Street and Number		10f. Zip Code 2085				itizen of What				
1017 Kennon Co	1017 Kennon Court  11 Marital Status 12. Was Decedent Ever in U.S. 13. V						ecify Yes or No-	Uni	nerican Indian,	
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3 🕅 Widowed 4 🗆 Divorce  15. Deced (Specify only high Elementary/Seconday (0-12) 12	College (1-4	or 5+)		NOT use retired) maker				Ι,	Own Hor	ne
17. Father's Name (First, Middle	Last)		liome	lliake I	18. Moth	ner's Nam	e (First, Middle			
George Rufus						lie		,		
19a. Informant's Name/Relation			19b. Mailin	g Address (Street				er, City o	or Town, State,	Zip Code)
Lawrence 0. E	ason/Son		1017	Kennon	Court	, Ro	ckville	, M	aryland	1 20851
20a. Method of Disposition	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  4 Donstion 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Elmwood Cemetery  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)  20d. Place of Disposition (Name of cemetery, crematory or other place)						Date	20c. l	20c. Location - City or Town, State	
							10	Henderson, NC		
21. Signature of Funeral Service	Nicensee	3400	22 RO	Name and Addre	ss of Facili	ty Rol	oert A. O West	Pun	ıphrey tgomer	Funeral Home, V Avenue
23a. Part 1. Enter the disease,	or complications that car		803 Ro	ckville,	Mary	land	20850	)-28	05	Approximate
shock, or heart failure. Lis	only one cause on each	line.						11031,		Interval Between Onset and Death
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Cause (Disease or linjury that initiated events	C									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or	as a consequ	ience of):							
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outco								23d. Date of	delivery
in the past 12 months?	1 Live Bi 4 Pregna		☐ Ectopic pregnancy ☐ Other (specify)							
g ☐ Unknown	9 Unkno	wn								
Part in Other significant conditions continuously to death but not resulting in the discense given in act.										
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Dementia							24a. Was	psy	prior	autopsy findings available to completion of cause of
								ormed?	death	n? Yes 2 □ No
25. Was case referred to medica examiner?	Hospital:	26. Place of Death (Check only one) Other:							Assisted	
1 ☐ Yes 2 🔀 No 27. Manner of Death	1 ☐ In	patient 2  injury	ER/Outpatier 28b. Time of	t 3 🗆 DOA	4 N	lursing Ho	ome 5 Resi	idence	6 X Other (S)	Assisted Decify Living
1 X Natural 5 ☐ Pend	/8 /1- m 4 fm	Day, Year)	injury	work	Yes 2	] No	Zou. Describe	now inju	ny occurred	
3 Suicide 6 Coul	d not be 28e. Place of	f Injury - At ho	me, farm, stre	et, factory, office						Rural Route Number,
	building	, etc. (Specify)					City or To			
29a. Certifier 1 📉 Certifyin (Check 2 🗌 Medica only one) 3 🗆 Certifyin	ng Physician: To the bes	t of my knowl	edge, death o	ccured at the time	, date and	place, ar	nd due to the ca	ause(s) a	and manner as	stated. he cause(s) and manner state
	ng Nurse Practioner: To			leath occurred at th	e time, dat			he cause	(s) and manner	as stated.
29b. Signature and title of certif	Tourse	Man	ms	29c. License						onth, Day, Year)
30. Name and address of perso	10ms/co	of doctor in	220/ 15== 5	D519	10			Ju	1y 27,	2010
30. Name and address of perso					100 (	2 <b>–</b> 100	) Rock	v:11	e. MD	20852

Registrar DHMH 17 Rev 7/2009

State

Patricia Tomsko Nay, M.D.
31. Date filed (Month, Day, Year)
32. Regis

32. Registrar's Signature

11119 Rockville Pike, G-100, Rockville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ MARGARET FERRARA Month R. 09:35 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 □ M 2 🛣 Hours July24, 1951 Director 219-56-6624 59 Usual Residence of Decedent show ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f shor or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No Maryland <u>Baltimore</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5009 Frankford Avenue 21206 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, 1 X Never Married 2 Married Yes 2X No Yes, Give ۾ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food Industry 11 <u>Waitress</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Paul Ferrara Geraldine McGraw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a ant: If item 27 is Air, Maryland 21014 Jerome F. Ferrara/Brother 701Hickory Limb Circle Bel 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Department of Important: If any injury or 7-29-10 Hanover, Maryland 4 Donation 5 Other (Specify) ArdentCremation, INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PNEUMONIA disease or condition resulting in death) WEEK Medical Due to (or as a consequence of): Examiner WEEK OSTEOMYELITI. Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò completed filled in by the funeral director, page 2 should be Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 XNo ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 Yes 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the within 2 State

only one 29b. Signaty

d title of certifier

EASTERN CHRISTINE MATIVD am 494D 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c, License number

D0070596

29d. Date signed (Month, Day, Year)

2010

JULY

AVENUE, BALTIMORE, MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc g905 7-30-10 vt
State of Maryland 7 Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month STUSIA :35 PM 20/0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 401 brighton Columbia Olum bia If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Hours 1 □ M 2 🛛 Min. Director 09-16-1610 86 24 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Howard Columbia 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7110 Minstrel Way 21045 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces Black, White, etc. ò þ 1 Never Married 2 Married Yes 2 X No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3X Widowed 4 □ Divorced Specify: White Completed Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade na Factory Worker Paco Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Barnabic Justine Piculich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6322 Kite Line Ct., Columbia, Md 21044 Melissa Paddock-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗆 Donation 5 🗷 Other (Specify) 7/30/2010 Hackensack Hackensack, NJ Signature of Auneral Service Licensee 22. Name and Address of Facility
Beaugard Funeral Home
869 Kinderkamack Road 07661 River Edge. 23a. Part 1 Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm - ate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? none 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes been a 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 No death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 32 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural work? 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D4485 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PCWY, Colombia Md. 21044 10910 S. Ivenen 31. Date filed (Month, Day, Year) 32. State 0 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 23a, pt.11 per doc 8906 8-3-10 vt. State of Maryland / Department of Health and Mental Hygiene 0 | 0

For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BE GECKLE -Month R 1:30A M 2010 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARF HEALTH AND KEHABILITATION FOREST HILL - OREST If Under Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min. 02 Manth Day Y 28 Country) 82 MD Director 217-22-9276 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits at Director Examiner must be notified MD Harford Forest Hill 1 Yes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? items 23a Funeral 1312 Grandview Ct 21047 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married "natural", or by within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (154 or 5+) Education Administrator Balt. Co. Board of Ed. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William E. Geckle Mary V. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any Injury or other trai 1312 Grandview Ct Fallston, MD 21047 Jean Geckle (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 07-30-2010 Fallston, MD Highview Mem. Gar. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of FacilitySchimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Parvi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate End Stage Cardiomyopathy Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 2 🗌 No 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, Atrial Fibrillation 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Congestive Heart Failure 24a. Was an cate has l autopsy performed? Yes 2 No 1 Yes 2 No certificate funeral director, æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: 은 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) David 5 032275 27.20 completed cause of death (Item 23a) (Type, Print 30. Name and address of person who PHATL ROAD - BE 615 Day, Year, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 7 2010 Joan Rose Grosscup :30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Joseph Medical Baltmore Center Towson MO 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Funeral 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. (Month, Day, Year 1 □ M 2 🔀 F Balt., Maryland 215-30-5565 76 Yrs **Director** August Usual Residence of Decedent 28a-f shov and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Timonium Baltimore Maryland 1 Yes 2 XX 10f. Zip Code United States Funeral 21093 305 Gailridge Road of America within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. ģ 1 Never Married 2X Married 1 ☐ Yes 2 🛣 No 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: white 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Licensed Practical Nurse Nursing Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Clyde Norman Kalkreuth Minnie Johnston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul J. Grosscup/ husband 305 Gailridge Road Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July 31, Meadowridge Memorial
Park 1XXBurial 2 Cremation 3 Removal from State ∄ ☐ Other (Specify) 4 Donation 2010 Elkridge, Maryland of Fur eral Service bicens Signatur 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of executed Due to (or as a consequence of): resulting in death) Last the burial the attending physician hed for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 🔲 Yes 2 🕱 No Day 5 Other (specify) Pregnant at time of death detached 9 Unknown 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 📉 No 24a. Was an autopsy performed? Yes 2 X No certificate | Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 No ၉ 1 Tyes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 🔼 Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital c 24 hours at Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

OSTER

Name and address of person who completed cause of death (Item 23a) (Type, Print)

160

32 Registrar's Sign

10-05654 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Kristen E. Hawley 010 23776 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 1535 hrs Medical Examiner Kristen Elizabeth 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** St. Agnes Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days Hours Director 28 Oct. 21, 1981 Country) New Yor 229-43-1594 1 M 2X F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 Yes 2 X No Little River South Harry Limore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene, restrict If tier 77 is marked other than "natural", or items 23a or 28a-f show or other tranmatic event, the Midical Examiner must be notified at once. or 28a-f show Carolina 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4300 Teakettle Court 29566 U.S.A. ō Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black. White, etc. Armed Forces? 1 X Never Married 2 Married Yes 3 Widowed Yes, Give Year 1 Yes 2 No specify: Specify: White Divorced ≦ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Restaurant Waitress 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sandra Race Dale Hawley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 4300Teakettle Court, Little River, SouthCar. Sandra Hawley/Mother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 K Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify. RiverviewCemetery 8-1-10 Oxford, New York 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Muchael | Maryello | 16009Harford Road, Baltimore Maryland 21214

23a. Part I. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart | Approximate Interval Physician Between Onset and /Medical Death Methadone Intoxication and Cocaine Use Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED 23a, 27, 28a-f per me g906 8-10-10 vt **X** UNPENDED ned by the attending physician detached for use as the burial Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. É 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, 24b. Were autopsy findings available peen 24a. Was an autopsy prior to completion of cause of has performed? death? ✓ Yes 2 No 2 No 1 Yes After this certificate 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital To the Hospital or Attending Physician: Be Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: Natural 1 Yes 2 X No within 24 hours after death. To the Funeral Director: Pending 7-28-10 10:42 am the <u>unknown</u> Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3015 Louisiana Ave. 6 X Could not be Suicide determined (Specify) Baltimore, Md. Homicide a residence 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number July 29, 2010

31. Date filed (Month, Day, Year State Registrar

DHMH 17 Rev 1/2001

OCME 2006

Carol Allan, MD

**ORIGINAL** 

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

OCME

**Physician** /Medical Examiner

**Funeral** 

Director

28a-f show must be notified at

ö items 23a

Examiner

"natural", or

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any injury or other traumatic event, the Medical once.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trai detached f ate has page 2 certificate this ieral Director: Af after death within 24 hours a

To the Funeral C

completely filled

Division of Vital Records, P.O. Box 68760,

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Yes 2 No 4 Pregnant at time of death 5 Other (specify)						
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown					
	·	24a. Was an autopsy performed?  1 Yes 2 \( \) No    24b. Were autopsy findings available prior to completion of cause of death?  1 \( \) Yes 2 \( \) No    1 \( \) Yes 2 \( \) No					
25. Was case referred to medical	- 26. Place of Death	h (Check only one)					
examiner? 1 X Yes 2 \( \subseteq \text{No} \)	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 Residence 6 Other (Specify)					
27. Manner of Death  1 Natural 5 ☐ Pending 2 Accident investigation	(Month, Day Year) Injury Work?	28d. Describe how injury occurred					
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, Cify or Town, State)					
	ysician: To the best of my knowledge, death occurred at the time, date and place, niner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.						

29c. License number 00069586

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

2010

State Registrar

Medical

Doriann 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 26 wonth Horde-Butler Marie Ellen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Joseph Richey House If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 02 36 Months Days Hours Min. 213-32-5382 74 Director Usual Residence of Decedent shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director or 28a-f st 1 X Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ral", or items 23a o Examiner must be Funeral 21207 U.S.A. 14 Mountbatten Ct. Unit 102 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Specify: Black "natural" 3 Widowed 4 Divorced Completed Year or Dates. ed other than "natu event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Therapist Sinai Hospital <u>12th grade</u> 2yrs Respiratory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and _
of Health an.
' tem 27 is marn.
'r traumatic e marked ၉ Lillian Wimbush Page 1 and 2 should be Summie Horde 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mountbatten court Unit 102, Baltimore, Richard Butler-Husband 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/31/2010 Woodlawn, Md Woodlawn permit. 22. Name and Address of Facility
March F/H West
4300 Wabash Av Signature of Funeral Service Licenses ternald 21215 Ave, Baltimore, Md 0 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate sh ck, or heart failure. List only one cause on more diate Cause (Final Interval Between
Onset and Death Physician/ uncer disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami certificate be execute attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Box in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 1 ☐ Yes ⊆ g ☐ Unknown Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be Records. 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? this certificate 1 ☐ Yes 2 ☐ No Division of Vital funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 6 Other (Specify) HOS 21 CL မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Anatural 2 Accident 5 Pending work 1 Yes 2 No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined thin 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie. сопретед Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 more 31. Date filed (Month, Day, Year) 32. Registar Signature State Registrar

B

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 30 per dvr e 905 7-30-10 yt

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Hookins Physician/ 20/0 07:29am On Medical no 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Secours 14 more If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days Hours Min 02 18 Year 217-68-3360 Director 53 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy rigury or other traumatic event, the Medical Examiner must be notified at once. or items 23a or 28a-f show miner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits Director Baltimore Randallstown Yes 2 No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21133 4250 Cayuga Road U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 10th grade Laborer Various Jobs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Martin Adams June Hopkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Lynette Hopkins-Wife</u> 4250 Cayuga Road, Randallstown, Md 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/30/2010 Zion Baltimore, Signature of Juneral Service License 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ monac 20455 Medical resulting in death) Examiner Due to (or as a consequence of): nears Sequentially list conditions, Examine use as the burial-transit Cause (Disease or linjury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death Vac 2 No the page 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available 24a. Was an After this certificate has autopsy prior to completion of cause of death? perform 2 PNc 1 Yes 2 No Yes the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniurv work? 1 ☐ Yes 2 ☐ No. 5 Pending 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29d. Date signed (Month, Day, Year) 006 1555 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bon Secours Hospital 1a 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 tems 10b, c, e, f per fh g905 7-30-10 vt State of Maryland / Department of Health and Mental Hygiene 0 1 0 23780 State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ 6:24 P M JUDI TH В HILNBRAND JIII Y Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1107 COURTLAND DRIVE **EL DER SBURG** CARROL Social Security Number If Under 1 Year | If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 X F Hours Min. Country 02/104/11946 Director 218-44-0275 64 MD Usual Residence of Decedent 10b. County Howard 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits must be notified at Funeral Director 1 🗆 Yes 2 🛣 No Jessup CARROLL - ELDERSBURG 10e. Street and Number 8061 10f. Zip Code 10g. Citizen of What Country? Round Moon Circle -1107 COURTLAND DRIVE 20794 <del>-21784</del> USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. injury or other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give WHITE 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MD STATE HEALTH DEPT 12 DATA ANALYST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည NAOMI SODIE MORRIS LUBITZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1107 COURTLAND DRIVE, ELDERSBURG, MD KAREN CREUTZER/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Pape nCINSP Sidon Warne of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or RUDOMÉR VEREIN CEM. 7/29/2010 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Lipe SOL LEVINSON & BROS., INC. 22. Name and Address of Facility Lichael 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or iinjury Examiner Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 No 9 Unknown g Unknown Division of Vital Records, P.O. cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 Unknown 1 Tes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Tes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 6 X Other (Specify) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury ocurred Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 31. Date filed (Month, Day, Year) 32. Registrar's Sig State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #6 per FH G906 8/03/10 JH of Maryland Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Evelyn Kramer 2010  $P^{M}$ July 28 4:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Potomac Valley Nursing Center Rockville 8. Date of Birth
(Month, Day, Year)
Feb. 5, 1 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign **Funeral** Hours New York 95 1915 Director 068-09-8774 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland must be notified at Director 1 XYes 2 No Washington D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral items 23a United States 20009 1847 Ontario Place NW 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Examiner Black, White, etc. ō 1 Never Married 2 Married þ within 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: "natural", 3 X Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Own Home Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental fitem 27 is marked ၉ Portnowitz Tda Goldstein Jacob 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20009 1847 Onatario Place NW, Washington D.C. Phyllis Kramer / Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 and Department of Informatic If ite any injury or ot cemetery, crematory or other place) 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Mt. Lebanon Cemetery | 8/1/2010 Adelphi, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician FAILURE TO THRIVE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** ADVANCED DEMENTIA Sequentially list conditions, many, leading to immediate cause. Enter Underlying Examiner Day to for as a considuence off Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury and-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the Unknown Division of Vital Records, P.O. been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 XNo 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has ours after death.

eral Director: After this certificate I filled in by the funeral director, pag 1 Yes 2 No 1 ☐ Yes 2 💢 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ᅆ 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) hours after To the Hospital of within 24 hours a To the Funeral Completed filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in Medical 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner. On the basis of examination a root state of the cause (s) and manner as stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of contine 29c. License number 29d. Date signed (Month, Day, Year) D0062435 July 29, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

SAYED ELSAYYAD, M.D.

31. Date filed (Month, Day, Year)

10110 MALEALS DR.,

ROCKVILLE, MD

20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 23782 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Robert A. Karcher, Jr. 9:19 A.M 2010 July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Worcester Co. Berlin If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Numbe 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) March 8,1969 1 🕅 M 2 🗆 F Mary land 217-02-0926 41 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at within 72 hours after death with the Maryland Director Harford County Forest Hill Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21050 2262 Phillips Mill Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married ρ Maryland 21215-0036 1 ☐ Yes 2 🄀 No If Yes, Give Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Amtrak Equipment Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H permit. Page 1 and 2 should be filt Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ၉ Robert Allen Karcher, Sr. Roberta Ann Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2262 Phillips Mill Road, Forest Hill, Maryland 21050 Melissa Karcher (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State July 26, 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Holly Hills Mem.Gdn. 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services-BelAir
3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Glioblastoma Multiforme 23 Months disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth 2 Live Gath 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year ed by the a detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? Completed by Seizures; aplastic anemia Records, 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed death? Yes 2 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Division of Vital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 Ty No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) July 26, 2010

10 V

State Registrar Jaishri Blakeley, MD 600 North Wolfe St., Baltimore, MD 21287 32. Registrar's Signature acks

30. Name applied address of person who completed cause of death (Item 23a) (Type, Print)

D0064099

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2<u>010</u> Physician/  $\overset{\text{Month}}{July}$ 22 8:03 P M Bernard M. W. Knox Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Montgomery <u>Bethesda</u> 8. Date of Birth (Month, Day, Year) November 24, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** , 1914 United Kingdom Days Hours 95 Director 046-16-2883 Usual Residence of Decedent . Page 1 and 2 should be filed within 72 hours are: ---tment of Health and Mental Hygiene.

rent if item 27 is marked other than "natural", or items 23a or 28a-f show
rent if item 27 is marked other the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Montgomery 1 Yes 2 X No Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4925 Battery Lane #704 20814 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 Divorced Year or Dates. WWII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Professor Academic 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernard Knox Rowena Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard M. B. Knox/Son 54 Litchfield Way, London NW11 6NG England, United Kingdom 20b. Place of Disposition (Name of Monts of Ermstery, crematory or other place) Crematorium, Inc. 20a Method of Disposition 20c. Location - City or Town, State permit. Page 1 and Department of H Important: If it any injury or o July 30, 2010 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Signature of Funeral Service Ligensee M01498 Bethesda, Chevy Chase 1 Inc. 7557 Wisconsin Avenue 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final terioscherotic DISTOISE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Month Year Yes 2 No ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Completed by 1 🗆 Yes 2 🗆 No 3 🗀 Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 Tes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, it may opinion, seal recommendation and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6 10 EMEROPACY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20814 Levnard MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

JUL 3 0 2010

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical JULY 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Himor Ba CITY OF BAITIMONE Univ. of Maryland Med. 6. Sex 1 M 2 D F 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 5/26/1932 Seoul Korea Director 216-80-1268 78 Usual Residence of Decedent or 28a-f show . Page 1 and 2 should be filed within 72 hours after death with the many......trnent of Health and Mental Hygiene.
rtant: If item 27 is marked other than "natural", or items 23a or 28a-1 shortant: If item 27 is marked other than "Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Baltimore Millersville 1 🗌 Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 568 Brightwood Road 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 🛣 No If Yes, Give þ 1 Never Married 2 Amarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Korean 3 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gae Sung Kim Soon Hee Jang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8388 Lochwood Road Pasadena, Maryland 21122 Hwan Kim / Son Tae injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place Hilltop Service Corp 7/30/2010 Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Cerebrovascular Physician/ disease or condition Medical resulting in death) Examiner silara Su uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 L 9 Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Mellitus, Hypertension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my anisism due to the cause(s) and manner as stated. Medical 29a. Certifier Definition in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. GROWE ST BAINMORE MO AUION

DHMH 17 Rev 7/2009

State Registrar

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 28 Physician/ Month Year 2010 12:40 AM Lane Richard Ludwig Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2332 Kateland Court Harford Abingdon 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 D F Months Min. Hours Feb 17, 1970 Maryland 40 Director 508-08-9409 Usual Residence of Decedent Department of Health and Martal Hygione. Important: or items 23a or 28a-f sho important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d, Inside City Limits Director Harford 1 Yes 2 No Abingdon 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2332 Kateland Court 21009 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 NO 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Director of Staffing Be Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Nancye Elaine Orth John Ernest Ludwig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Kaiser /Wife 2332 Kateland Court Abingdon, MD 21009 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jul 31 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 4 Donation 5 Other (Specify) 2010 permit. Signature of Funeral Service Licenses 22. Name and Address of Facility
Cremation and Funeral Alternatives MO1443 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o'heart failure. List only one cause on each lije. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ to Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and defected for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year 1 Yes 2 No Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performed? Yes 2, No 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director, After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Certificate; To Be 26. Place of Death (Check only one, 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Natural Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Examiner: On the pasis or examination and/or investigation, in this opinion, seal occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Dimon

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32 B

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 1 0

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 29, 12:00 AM ^{Year} 2010 Arlean Lutz Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Min. May 04, Year) 1934 1 M 2 F 76 Hours Maryland 236-50-0471 Yrs Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director Baltimore Rosedale 1 Yes 2 No 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8909 Lennings Lane 21237 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Race - American Indian. Armed Forces? Black, White, etc. ò 1 Never Married 2 Married o, 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural" White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) Manufacture Box Packer Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked oth any Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Sions Dolly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Lutz /Husband 8909 Lennings Lane Rosedale, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of Jul 30 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Beltsville, Maryland Chesapeake Crematory 2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Cremation and Funeral Alternatives MO 144 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examin sician and burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ as been signed by the atter in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Yes 2 Unknown q 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 Yes 2 No Yes ne Hospital or Attending Physician: The 24 hours after death.

The Funeral Director: After this certifical pleted filled in by the funeral director, p. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 D Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident iniury 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of TONSON M MANUES Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 23787 State of Maryland / Department of Health and Mental Hygien  $\stackrel{2}{\sim} 0 \, \, 1 \, \, 0$ Certificate of Death Reg. No. 2. Date of Death

1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** Alma Elizabeth <u>Liversedge</u> July 28, 2010 11:05 AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care Health Services Rossville Baltimore If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday, 8. Date of Birth (Month, Day, **Funeral** Days Year) Months 1 □ M 27亿 F 12/31/1913 Director 379-05-9555 96 Michigan Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shor the Medical Examinar must be notified at Director 1 □Yes 🎾 No Maryland Baltimore Middle River the 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? with permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, I'm Medical Examiner must once. by Funeral 1215 Third Road U. S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify. 3X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Assembly Line Worker</u> Automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Charles Allen Flora Cook 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doug Jones (Personal Rep.) 404 N. Marlyn Avenue Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/2/2010 Holly Hill Memorial Gardens MIddle River, MD 21. Sign flire 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 23a Part 1 Chief the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Imm late Cause (Final disr ase or condition reculting in death) **Physician** aronan /Medical Due to (or as a consequence): Examiner protervour Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner nsequence of): physician and the burial-transit Box 68760, Due to (or as a consequence of): Physician/Medical nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy for in the past 12 months? Month 5 Other (specify) P.0. ned by the detached t 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed this certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 🛛 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Attending 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ospital or A hours after 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

Records, Division of Vital within 24 hours arter www.

To the Funeral Director: After the fulled in by the full

> State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

Eutaw Street #208 Baltimore, Md

State of Maryland / Department of Health and Mental Hygien

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 27^{Day} 2010^{Year} Ju1y**Physician** Rebecca A. Longstreet /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Sykesville Transitions Health Care If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 12/21/1933 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min New Jersey 1 □ M 2 X F 157-24-0703 76 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a "Moral or a mind or in this death any injury or other traumatic event, it a "Moral or a mind or in this death." 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Sykesville Completed by Funeral Director Carroll Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21784 7309 2nd Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 1 □Yes 2 No Specify 3 ☒ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 7Yrs. College (1-4or 5+) Homemaker/Care Giver Housewife Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Conrad Eichinger Rebecca A. Archer ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1003 35th Street Phenix City, Alabama 36867. 19a. Informant's Name/Relationship (Type. Print) Daniel M. Longstreet(Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation 07/28/2010 Sykesville, Md.

23a. Part 1. Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or as a consequence of)

Due to (or as a consequence of)

Due to (or as a consequence of):

Physician /Medical Examiner

P.O. Box 68760,

Division of Vital Records,

Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innertal director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Be Certification: To

Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Immediate Cause (Final

disease or condition resulting in death)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Fune at Service Licensee

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

22. Name and Address of Facility Haight Funeral Home & Chapel

P.O. Box 195 Sykesville, Md.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

ccleritic Cardiovascalar

24a. Was an autopsy perform 1 ☐ Yes 2 NO

28d. Describe how injury occurred

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐No

23788

3. Time of Death

1 □Yes 2 No

Approximate Interval Between Onset and Death

6.50 A

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 5 Pending investigation 1- Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 6 ☐ Could not be

Hospital:

Other: 

A Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 - Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of ce

29d. Date signed (Month, Day, Year) 7110

30. Name and address of person who completed cause of death (Item 23a) (Type, Point) ANZIQ State

Medical

(Attmood) 31. Date filed (Month, Day, Year).___

Registrar's Signature

and manner stated.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20c per fh g905 7-30-10 vt
State of Maryland / Department of Health and Mental Hygiene Reg. No 20 1 - State Registrar 23789 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 27^{Day} Physician/ JULY 2010ar 2:40 P M ROSE LUDMER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TOWSON GILCHRIST HOSPICE CARE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country)

NTV **Funeral** Min. Hours 1 🗆 M 2 🕱 F 09490894921 Director 069-16-2264 88 Yrs Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d, Inside City Limits 10a, State 10b. County the Maryland Director 1 ☐ Yes 2X☐ No TIMONIUM BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a or dical Examiner must be Funeral Page 1 and 2 should be filed within 72 hours after death with iment of Health and Mental Hygiene. 21093 USA 12261 ROUNDWOOD ROAD, #201 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Black, White, etc. Armed Forces 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 ▼Widowed 4 □ Divorced Completed לאוסטריב. th and Mental Hygiene. 27 is marked other than "natural": ביני פעפחt, the Medical E Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ACCOUNTING ACCOUNTANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ SCHWARTZ BESSIE ERLICHT MAX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is BROADMEADE COURT, COCKEYSVILLE, MD 21030 LYNN LUDMER/DAUGHTER other Baltimore, 20c. Location - City or Town, State
Owines Mills. Md. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 K Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
MARYLAND VETERANS CEM injury or 7/29/2010 Becation 5 Other (Specify) Signa ure o Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS. any 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each life. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EMPLICATIONS Physician/ MONTHS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ rascuutis 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an EMPHYSEMA Hospital or Attending Physician: The law page 2 s autopsy perform ATRIAL FIBRILLATION Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospital: 2**X** No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Affer injury work?
1 Yes 2 No 5 Pending 1 X Natural Accident within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗀 only one 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 164395 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N CHAPLES ST, SMITE 4105 BALTIMARE, MD 21204 DANIEWE DOBERMANIMO 31. Date filed (Month, Day, Year)

State

Registrar

3 0 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29d per doc g905 7-30-10 vt State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July 2010 07:00 PM Mary Margaret Myers Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 451 Magothy Bridge Road Pasadena Anne Arundel Year If Under 24 Hrs.
Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) Oct. 26 1917 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🙀 F Director 218-18-8420 92 Yrs Oct. MD Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 451 Mogothy Bridge Road 21122 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 🔯 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₺ No Specify: Specify: White 3 Wildowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 11College (1-4 or 5+) Box Company Packer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Franklin Eyring Margaret Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (daughter) Beverly Daniel 451 Magothy Bridge Road, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of July Date 20c. Location - City or Town, State cemetery, crematory or other place, 29 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Baltimore, Maryland Oaklawn Cemetery Signature of Funeral Service Insee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the de ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Chalangto Carmomer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 1 | Yes 2 | 9 | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital Other: 1 Tyes 2 NO 욛 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [ only one) 29b. Signature and title of Certifie 29c, License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person ath (Item 23a) (Type, Print) Gen Rame to Hos 0

State Registrar 31. Date filed (Month, Day, Year)

32. R

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Tracy Moore	1-For State Registrar  Certificate of Death  Certificate of Death  Reg. No. 2010 2379											
Physic Medical Exan		Decedent's Name (First, Middle, Last)				Date of Dea     Month	oth Day Year	3. Time of Death				
		4a. Facility Name (if not institution, give street and number) Sinai Hospital	4	b. City, Town, or Location	n of Death	July 28, 2	4c. County of E					
Funera	Г	5. Social Security Number 6. Sex 7. Age (In yrs. 1	last birthday)	Baltimore  If Under 1 Year If Un	der 24Hrs.	8. Date of Bir	th(MM/DD/YYYY) 9	NA Birthplace (State or				
Directo		218-76-7561 1KM 2 F 43	Yrs.	Months Days Hou	ırs Min.	02-08		oreign Country) NC				
' any		Usual Residence of Decedent  10a. State 10b. County 10c. City,	, Town or Location	on				10d. Inside City Limits				
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72 hours after death with the Maryland n"matural", or items 23a or 28a-f sho al Examiner must be notified at once.	Director	3730 Manchester Avenue		10f. Zip Code 21215		1	Og. Citizen of What	Country?				
th with	Funeral			Decedent of Hispanic Or	rigin? ( Spe	ecify Yes or No	USA - 14. Race - A	merican Indian, Black, c. African				
ter deat ", or ite		1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	i _	s, specify Cuban, Mexica		Rican, etc.)						
nours af atural xamin	ed by	or Dates:	16a. Decedent'	s Usual Occupation (Give	kind of w	ork done	Specify: A  16b. Kind of Busine	merican ess/Industry				
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21215-0036 wild be filed within 7 Mental Hygiene, marked other than c event, the Medica	o Be	James Sims  19a. Informant's Name/Relationship (Type, Print)	T - 22 - 22 - 22	] Bea	atri	ce	Moor	_				
C # B # E	δ	Corev Larkins-Cousin	196. Mailing /	Address (Street and Nur	mber or Ru	ral Route Num	ber, City or Town, Si	tate, Zip Code)				
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati		20a. Method of Disposition 20b. F						re, MD 21229				
Baltimore, bermit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify:  21. Signature of Euperal Service Ligensee	letro C	rematory	07-	30-10	Catons	ville, MD				
Depa Impo		monghe	0.00	ne and Address of Facilit	r Sti	reet B	altimore	ome P.A. e,MD 21217				
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. failure. List only one cause of each line.	Do not enter the	mode of dying, such as o	cardiac or r	espiratory arre	st, shock, or heart	Approximate Interval Between Onset and				
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	er	Sequentially list conditions, if any, leading to immediate  b.  Due to (or as a consequence of)										
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and and transit	a Ex	d										
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6876 ertifical ding ph	an/N	past 12 months?	2 Fetal		pregnanc	у	23d. Date of delive Month	ery Day Year				
Box 68760, he death certificate be executed in the attending physician and hed for use as the burial - transit	Physician/M	1 Yes 2 No 9 Unknown Pregnant at time of deal	th 5 Other	(Specify)								
b, P.O.  ires that the signed by the detache	by P	Part II. Other significant conditions contributing to death but not res	sulting in the und	erlying cause given in Pa	irt I.			to the cause of death?				
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Vital Records sysician: The law requi his certificate has been i	Completed					autopsy perform	prior to					
tal R	B B	25. Was case referred to medical examiner?		26.Place of Death (	Check only	1 Yes 2 y one)	V No 1	Yes 2 No				
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Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should by	Certification:	1 Natural 5 Pending (Month, Day, Year)	Fd 5:15	4 Ven o XI		a. Describe ho $\mathrm{nk}$	w injury occurred					
Division spital or Attendours after death neral Director: filled in by the	rtific	3 Suicide 6 Could not be 28e. Place of Injury - At hom	ne, farm, street, fa			f. Location (Str.	eet and Number or F	Rural Route Number, City Caster Ave				
bou hou y fill		4 Homicide determined (Specify) NOUSE 29a. Certifier Check only 1 Certifying Physician: To the best of my knowledge		at the time, date and place		altimor	e, MD					
To the Hos within 24 h To the Fur completely	8	2 Medical Examiner: On the basis of examination and and manner stated.	//or investigation,	in my opinion, death occ	urred at the	e time, date an	d place, and due to	the cause(s)				
,		29b. Signature and title of certifier		29c. License number O.C.M.E.			9d. Date signed <i>(M</i>	onth, Day, Year)				
0		30. Name and address of person who completed cause of death (Item 23	3a)	J. J. J. J. J. J. J. J. J. J. J. J. J. J			July 29, 2010					
Sta	to i			et, Baltimore, MD 2	21201							
Sta	169	11. Date filed (Month, Day, Year) 32. Registrar's Signature										

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

10万 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rosalinda McKenna 10:15 PM July 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death A Oak Crest Care Center Parkville Baltimore 5 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😿 F Months Hours Min (Month, Day, Year Marvland Director 262-42-7044 96 1913 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits orant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director MD Baltimore Parkville 1 🗌 Yes 2 😾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 8800 Walther Blvd. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian. þ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 ☐ Divorced 0 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 72 and 2 should be filed within 72
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:em 27 is marked other than State of Maryland Elementary/Seconday (0-12) College (1-4 or 5+) Lab Technician Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alfredo Lassise Rosa Rivera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan DeCarlo/Granddaughter 1706 Jackson Road, Baltimore, MD 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July 28, Page 1 Department of Important: If it þ cemetery, crematory or other place)
Evans Funeral 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Forest Hill, Maryland 2010 Bel 22. Name and Address of Facility Evans Funeral Signature of Funeral Service License Chapel & Cremation Services L. Parkville, MD 21234 Harford Rd Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im riediate Cause (Final di≁ease or condition Ph_sician/ Dementia Medical T sulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease on impury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: Certificate: To 1 🗋 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 1 Natural 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🛱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis or examination array or investigation, in this opinion, accurate the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARKVIlle, MD. 21234 WALTHER Blvd. Alice BRAZIER 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of M	-	Certificate of		ена пу	Reg. N2 0	10	23793
	Physic	an	1. Decedent's Name (First, Middle, L					2. Date of De Month		Year	3. Time of Death
-	/Medi		Angela May O					7	26	10	2:45 PM
	Exami	ner	4a. Facility Name (If not institution, g	4 7		1	r Location of Death			ty of Death	
	Funeral			yare Ho Sex 7. Ag 1□M 2\x F	e (n yrs. last birt	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month 12)	th	9. Birth	place (State or Foreign intry) yland
	Director		Usual Residence of Decedent		93	115.		May 21	, 1317	Mar	yrand
	/land iow		10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	a-fsh	cţo	MD Balti	more		Nottingham					1 □Yes 2X No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen o		intry?
>	ath w	lal	4040 Cliffvale			21236			USA		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Modical Expredient must be rottlind at once.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 □Yes 2⊠ If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub 1 □Yes 2 □KNo	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Spec	ack, White	ican Indian, etc. nite
5-0	72 hc	etec	15. Decedent's (Specify only highest of	Education trade completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	oation during most of worki	ng	16b. Kind of	Business/I	ndustry
121	within ene.	dmo	Elementary/Secondary (0-12)	College (1-4or	5+)	"life. DO NOT use retire. H <b>omemaker</b>	d) -		At Ho	me	
<b>d</b> 2	filed Hygi other	ပ္သ	17. Father's Name (First, Middle, La.	st)			18. Mother's Name	(First, Middle	, Maiden Surna	ame)	
lan	Aental Aental rked c	To Be	George Cannin	g			Mary V	<i>l</i> eir			
, Maryland	und 2 shou alth and M 27 is mai		19a. Informant's Name/Relationship William Ortman—s		19b. 40	Mailing Address (Street 40 Cliffval	and Number or Rura e Road-Not	Route Numb tingha	er, City or Tow m, Maryl	n, State, Z and 2	ip Code) 21236
Baltimore,	Pages 1 ament of He ant: If item ury or othe		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec		20b. Place of cometer Evans and Cr	Disposition (Name of Function of Char emation-Bel		ate 10	20c. Location Forest	•	own, State ,Maryland
Balt	permit. Departi Import any Inj		21. Signature of Funeral Service Lic	ensee Mc Lass	·-	22. Name and Addre Evans Fune 8800 Harfo	ral Chapel rd Road-Pa	and Carkvill	rematic e,Maryl	n Ser and 2	vices 21234
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that caused	d the death. Do n	ot enter the mode of dyi	ng, such as cardiac c	or respiratory a	ırrest,	//	Approximate Interval Between
- North	Physician		Immediate Cause (Final disease or condition	- Cerek	1	ascular	accide	\ \			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of	4 25					
	Lxammer	ř	Sequentially list conditions,	b. Chro	a consequence of	idney	diseas	, e			
	nsit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence c	7					
Ć,	tificate be executed ig physician and as the burial-transit	Exal	that initiated events resulting in death) Last	C Due to (or as	a consequence of	rf):					
68760,	ate be nysicia ne bur	cal		d							
89	artifica ing ph as th		IF FEMALE:						1	all:	270
P.O. Box	Physician: The law requires that the death cert this certificate has been signed by the attendin rid director, page 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	sy			ate of deli Month	very Day Year
σ.	that ned b	by Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlying cause give	ren in Part I.	23e. Did 1	tobacco use co	ntribute to	the cause of death?
rds	iw requires that s been signed I should be det							1 🗆	Yes 2 ☑ No	3☐ Pro	bably 4 🗆 Unknown
of Vital Records,	he law re te has bee age 2 sho	Completed							psy ormed?	prior to c death?	opsy findings available ompletion of cause of
ita	ysician: The lis certificate hadirector, page	BeC	25. Was case referred to medical	T			26. Place of Death	1 □ Yes (Check only o		TLIYes	2 □No
<u></u>	hysic this ce al direc		examiner? 1  Yes 2 No	Hospital: 1 ☑ Inpati	ent 2 ER/Out	tpatient 3 □ DOA Oth	er: 4 ☐ Nursing Ho	me 5 ☐ Resi	idence 6 □C	ther (Spec	ify)
o L	ing P	Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ıry 28b. T ı <i>y, Year)</i> Ir	ijury Wor	Ŕ?	28d. Describe	how injury occi	urred	
Division	ttend death ttor: /	icati	2 Accident investigati 3 Suicide 6 Could not	he l	ury At home for		Yes 2□No	Of Location (	Ctroot and Nov	where or De	m l Doute Mumber
Σ	or A after of Direct	ertif	4 ☐ Homicide determine	d 28e. Place of Inj building, et	c. (Specify)	m, street, factory, office	ľ	City or To	wn, State)	nber or Hu	ral Route Number,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Co	29a. Certifier 1 Certifying I	Physician: To the best aminer: On the basis of amd manner st	f examination an	, death occurred at the tid/or investigation, in my	me, date and place, opinion, death occurr	and due to the ed at the time,	e cause(s) and date and place	manner as e, and due	stated. to the cause(s)
	To the within 2 To the I complet	Me	29b. Signature and title of certifier	1		29c. Licens	se number		29d. Date sign	ned (Month	, Day, Year)
			DA A			Res	0000		7-	26-	10
	61		30. Name and address of person wh	o completed cause of c	leath (Item 23a) (	Type, Print)					
	21		Dr. Ala Ahmo	d 9000	Frankl	in Squar	e Drive.	Balti	more,	MD	21237
	Sta Registi		31. Date filed (Month, Day, Year) <b>JUL 3 0 2010</b>	32. Registr	ar's Signature	Kel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month :50 PM 2010 Parsons July Julius Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs (Month, Day Year) March 22, 1 ₹ M 2 □ F Months Hours Min **Director** 165-36-3762 63 1947 PA Usual Residence of Decedent show than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1715 Gabriel Court 21114 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Armed Forces?

1 XYes 2 No Black, White, etc 1 Never Married 2 X Married ۾ Baltimore, Maryland 21215-0036 If Yes, Give Vietnam Year or Dates. Conflict 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Technology Assessment Elementary/Seconday (0-12) College (1-4 or 5+) Production Manager and Transfer Inc. other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o permit. Page 1 and 2 should be Department of Health and Menta Important. If item 27 is marked any injury or near ပ္ Julius C. Parsons, Sr. Jean Kennedy Farr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beatrice Parsons 12697 Old Dayton Road, Brookville, Ohio 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Eversole
Cemetery 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Montgomery County, Ohio 7-28-2010 5 Other (Specify) 21. Signature of Fi eral Service Lio 22. Name and Address of Facility Rogers Funeral Home Main St., 110 W. Trotwood. OH 45426 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ em bolus disease or condition resulting in death) OUIMONAMY day Medical Examiner Due to or as a consequence of) Sequentially list conditions Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No detached 9 Unknown Unknown s been signed by i should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Cellulitis Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? diabetes 24a, Was an page 2 s autopsy performed this certificate has 2 K No Yes 2 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 🗷 No 잍 1 🗷 Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

Records, P.O. Box 68760 Division of Vital Hospital or Attending Physician:

> 10 State

Medical

29a. Certifier

29b. Signature and title of certifier

200

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

069566

21401

I Velisse Michel, MD

29c. License number

10-05611 UNK UNK Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

UNK UNK		1- For State Registrar		of Maryland		artment o rtificate o			Mental F		Reg. No	2010	23795
Physicia Medical Examin		J	e (First, Middle,Last) ermaine	Isaac		rker				2. Date of De Month July 27, 2	Dav	Year	3. Time of Death 0429 hrs
		4a. Facility Name (i 5100 Willist	if not institution, give on Street	street and number)			-	Town, or Lo	ocation of Deat	h	4	lc. County of Death	1
Funeral Director		5. Social Security N 219-08	-2473 1 <b>EX</b>	7. Ag	e (In yrs. 1	last birthday) Yrs	Monti	der 1 Year hs Days	If Under 24Hr Hours Min	_		M/DD/YYYY) 9. Bir Foreig Co	
any		Usual Residence of 10a. State	f Decedent 10b. County		10c. City	, Town or Locat	ion						10d. Inside City Limits
rland -f show	Ē	MD	NA		Ba	altimo:							1 X Yes 2 No
the Mar a or 28a tifted at	Director	10e. Street and Nur 4219 G	mber ranada A	venue			10f, Zip	2121	.5		10g. Ci	tizen of What Cou USA	ntry?
leath with r items 23.	Funeral	11. Marital Status 1 X Never Marrie	ed 2 Married	12. Was Decedent Armed Forces? 1 Yes 2			s Decede es, speci	ent of Hispa ify Cuban, N	anic Origin? ( S Mexican, Puert	pecify Yes or No Rican, etc.)	lo-	14. Race - Amer	ican Indian, Black, African
s after c	Q F	3 Widowed	4 Divorced	f Yes, Give Year or Dates:		1		X No			Lio	Specify: Am 6	
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	Elementary/Seco	ondary (0-12)	College (1-4 or s			ost of wo	rking life. D	n (Give kind of IO NOT use re		G	eorge .	J.
15-00 iled with Hygien I other		17. Father's Name (	(First, Middle, Last)			<u>.                                    </u>				e (First, Middle,	Maider	,	<u>Jompany</u>
2121 buld be f Mental marked c event,	o Be	Milton 19a. Informant's Na	Ω Pa me/Relationship (Typ	rker		19b. Mailing	g Address		OYCE		igh mber,C	t City or Town, State	, Zip Code)
MD nd 2 sho alth and m 27 is			a Parker	-Aunt		4219	9 Gr	anad	a Ave	nue Ba	<u>lti</u>	more,MI	21215
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumartic event, the Medican injury or other traumartic event, the Medican pages 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 2000 and 20			Cremation 3	Removal from Sta	ate (	Place of Dispos crematory or oth It. Zic	ner place	)	- 1	Date - 03 - 10		Location - City or	•
altin rmit. Pa apartmet portan jury or	1		Other Specify: neral Service License	e //.		22. N	ame and	Address of	Facility	ylie	Fun	eral Ho	ome P.A.
m 원칙표표 Physician		23a, Part I, Enter the	e disease, or complic	dions that caused	the death								, MD 21217
/Medical Examiner		failure. List onl Immediate Cause (F or condition resultin	y one cause on each Final disease a. M	n line. lultiple Gunshoue to (or as a conse	t Woun	ıds	TO MIOGO	or dying, sa	orras caratas c	n respiratory an	1031, 311	ook, or near	Between Onset and Death
	اير	Sequentially list cor if any, leading to im		ue to (or as a conse	ori lence o	f\r							·
	ledical Examiner	(Disease or injury the events resulting in co	rfying Gause nat initiated C	ue to (or as a conse									
60, tre be executed hysician and e burial - transit	lgal L	UNPENDED	d	AMENDED									
8760, ifficate bong physicast buns its the buns.		IF FEMALE: 23b. Was decedent p	pregnant in the	23c. If yes, outcom	ne of pregi		al death	3 🗆	Ectopic pregna	ancv	23	d. Date of delivery	) Day Year
Box 6876 e death certificate the attending phy ed for use as the	Physician/	past 12 months		Pregnant at 9 Unknown	time of de	ath -	ner (Spe				1		
P.O.	≦	Part II. Other signif	icant conditions c	ontributing to death	but not re	esulting in the u	nderlying	cause give	en in Part I.				the cause of death? ably 4 Unknown
cords, P	Completed										psy orm <u>ed</u> ?	prior to c death?	topsy findings available ompletion of cause of
tal Rec	a l	25. Was case referre	ed to medical		Q			26. Place of	Death (Check	1 ✓ Yes only one)	2N	lo 1 🗸 Ye	s 2 No
F Vita	0	examiner?  1 V Yes 2  27. Manner of Death	2 No	spital: 1 Inpatier		ER/Outpatient				g Home 5		ence 6 🗸 Other	Scene
ision of Attending Pher death.	ation:	1 Natural 2 Accident	5 Pending Investigation	28a. Date of Injur FOUND: Jul 27, 2010	ear)	28b. Time of Ir FOUND: 0405 hrs	ijury  2	28c. Injury a	2 No	28d. Describe Subject sho		ury occurred	
Divis ospital or At hours after d uneral Direc	Certification:	3 Suicide 4 ✓ Homicide	6 Could not be determined	28e. Place of Inju			t, factory,	office build	-	or Town. 5	State)	and Number or Rur et, Baltimore, MI	ral Route Number, City
To the Hoss within 24 hd To the Fun completely	.   ق	29a. Certifier 1 (Check only 1 one) 2	Certifying Physician Medical Examiner: O	: To the best of my n the basis of exam nd manner stated	knowledg nination ar	ge, death occurr nd/or investigati	ed at the	time, date opinion, de	and place, and eath occurred a	due to the caus t the time, date	se(s) ar and pla	nd manner as state ace, and due to the	d. ∋ cause(s)
6 2 2 2	Ĕ	29b. Signature and t		1 1.	/		290	License n			1	Date signed (Mon	th, Day, Year)
2	-	30. Name and addre	ss of person who cor	npleted cause of de	eath (Item	23a)		O.O.IVI.	<b>-</b> .	-	July	27, 2010	
		Jack Titus M		nief Medical Ex		0	n Stree	et, Baltim	ore, MD 21	201			
Stat Registra	ie ar	31. Date filed (Moath	02010	32. Registrar	signatu	arke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#26 per PHYS, G905, 7/30/2010, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 2010 Julv Physician/ Prisco Amelia Ruth Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore County Nottingham
If Under 1 Year | If Under 24 Hrs. 4209 Hollow Spring Lane Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) (Month, Day, Year) April 24,1931 Funeral Months Days Hours 1 🗆 M 2 🖾 F Pennsylvania Yrs. 187-24-2288 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County items 23a or 28a-f show 10a. State iral", or items 23a or 28a-f show Examiner must be notified at. and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Nottingham Balto. Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21236 4209 Hollow Spring Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc Armed Forces? 1 Never Married 2 X Married White 1 ☐ Yes 2 🕅 No Specify: þ Baltimore, Maryland 21215-0036 Yes, Give 3 🗌 Widowed 4 🗆 Divorced Completed "natural" 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education permit. Page 1 and 2 should be filed within 721 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, the Medic once. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care R&N 18. Mother's Name (First, Middle, Maiden Surname) Be 17, Father's Name (First, Middle, Last) Evelyn S. Schultz ပ Elmer E. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nottingham, Md. 4209 Hollow Spring Lane Spouse Joseph Prisco 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Halethorpe, MD. 7-29-2010 Meadowridge 22. Name and Address of Facility Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licensee 9705 Belair Road Nottingnam, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ac rci 20 m Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of) Medical **Examiner** Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the con Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed ling physician and e as the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery IF FEMALE: nse 23b. Was decedent pregnant 3 Ectopic pregnancy Year Dav Month in the past 12 months? Other (specify) Pregnant at time of death for a 🗌 Unknown been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 12 funeral director, page 2 this certificate has 2 🗆 No 1 Tyes 26. Place of Death (Check only one) 25. Was case referred to medical Be ( Other 4 Nursing Home 5 X Residence 6 Other (Specify) Outpatient 3 DOA 1 Yes 2 No 1 Inpatient 2 Certificate: To 28d. Describe how injury occurred 28b. Time of 28c. Injury at 28a. Date of injury (Month, Day, Year) 27. Manner Death within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 3 Suicide 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one 29d. Date signed (Month, Day, Year) Signature 21212 who completed cause of death (Item 23a) (Type, Print) 200 East 33rd Street Suit 136 30. Name and addr s of person 1 Ov 32. Registrar's Sig 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 26 2010 Month Physician/ 2:30 PM Jessie Μ. Pritchett Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Joseph Medical Center 21204 TOWSON MD Baitimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Ye 1 □ M 2 🔀 Country)
Kentucky Hours 85 Yrs Director 404-28-2294 Usual Residence of Deceden or 28a-f show e notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2'No MD Lutherville Timonium Baltimore ō 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ms 23a or Funeral 21093 United States 2300 Delaney Valley Road items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: "natural" 3 Widowed 4 Divorced Completed White 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) White Coffee Pot 8 Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ . Page 1 and 2 should be f ment of Health and Menta tant: If item 27 is marked Siles Lora Sherman Strunks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jones /Daughter Linda 6512 Lewis Road Baldwin, MD 21013 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State Jul 30 4 Donation 5 Other (Specify) Parkville, Maryland Parkwood Cemetery 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Alternatives M01443 Pastures Drive Towson Maryland 21286 23a. Part 1. Bater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Kespiraton tailure Physician/ disease or condition resulting in death) Jucars Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy jo in the past 12 month Month Day Year page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Ves 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 24 hours after death.

• Funeral Director. After this certificate has leted filled in by the funeral director, page 2 to autopsy 2 🗹 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 No ☐ Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

DHMH 17 Rev 7/2009

Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and addre

s of person who completed cause of death (Item 23a) (Type, Print)

D.O

Richard trankel

H0058708

<u>7601 OSIER DRIVE, TOWSON</u>

MD 21204

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			1 - For State Registrar	State of Ma		artment of Health and rtificate of Death		ene 010	23798
	Physicia	an	Decedent's Name (First, Middle     Lorene				2. Date of Death Month July	Day Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution,	Perry n, give street and number)		4b. City, Town, or Location of Dea		21, 2010	
	_Xaiiiii		Transitions He	ealth Care C	enter	Sykesvill		Carro	11
	Funeral Director		5. Social Security Number 220-22-4385		e (In yrs. last birthday) 83 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Bird Co	thplace (State or Foreign buntry) TN
	yland		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation			10d. Inside City Limits
	Ba-f st	Director		Carroll		Woodbine			1 ☐ Yes 2 🔀 No
	with the		10e. Street and Number 3560 Woodbi	ino Pood		10f. Zip Code 21797	10	g. Citizen of What Co USA	ountry?
	deeth	Funeral	11. Marital Status	12. Was Decedent   Armed Forces?	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Ame Black, Whit	
25	s 1 and 2 should be filed within 72 hours after deeth with the Maryland them 27 le marked other than "naturel", or Iteme 23a or 28a-f show other treumatic event, the Modical Examinat must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced		Vn.	1 ☐ Yes 2 ☐ No Specify:	to ritioan, dio.,		hite
5	"natu	lete	15. Decedent' (Specify only highes	's Education of grade completed)	(Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	orking 1	6b. Kind of Business	/Industry
7 7	d with	Completed	Elementary/Secondary (0-12) 5	College (1-4or 5	5+)	Homemaker		Domes	tic
	be file ital Hyg id othe event,	Be	17. Father's Name (First, Middle, L				me (First, Middle, M	laiden Sumame)	
y	z should be filed with and Mental Hygiene. Ie marked other that eumatic event, the	은	John Barna 19a. Informant's Name/Relationsh		19b. Maili	Nora  Nora  ng Address (Street and Number or R	Winkles ural Route Number.	City or Town, State, 2	Zio Code)
1	and 2:		Mrs. Helen Pheb			Woodbine Road, W			
	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other frei		20a. Method of Disposition  1. Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp.	3 □Removal from State pecify)	20b. Place of Disponsion Sharon Ba	osition (Name of matory or other place) aptist Cemetery 7		Oc. Location - City or West Frie	
חשור	permit. Departimport any inj		21. Signature of Funeral Service L	11 11 1	60769 HA	Name and Address of Facility NIGHT FUENRAL HOM ) Box 195 Sykesvi	E & CHAPE 11e, MD 2	L, PA 1 <b>7</b> 84	
			shock, or heart failure. List of	complications that caused only one cause on each lin	ne.	ter the mode of dying, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	a consequênce of):	Cancer			
	Examiner		Sequentially list conditions	b	a consequence on).				
	nslt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):				
s s	execu	Exar	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):				
	filcate be executed physicien end is the burial-transit	edicai		d					
\ \ \	- 0.0	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		75		23d. Date of de	livery
) )	by the achec	Physician/M	in the past 12 months? 1 □ Yes ②☑No 9 □ Unknown	4☐Pregnant at		□Ectopic pregnancy □ Other (specify)		Month	Day Year
·	res ma igned be det	2	Part II. Other significant condition	ins contributing to death bi	ut not resulting in the u	inderlying cause given in Part I.		acco use contribute to s 2 □ No 3 □ Pr	
	been si should I	leted	- THORIC OF	13112 CAVE	2 / 1(	4 Dis 235	24a. Was an		robably 4 ☐Unknown  utopsy findings available
	ne iav ete hes page 2	Completed					autopsy perform	prior to death?	completion of cause of
	r this certificete	Be	25. Was case referred to medical examiner?			100	ath (Check only one	)	
5	ar this o	7: To	1 ☐ Yes 25 No  27. Manner of Death	Hospital: 1 ☐ Inpatie	ry 28b. Time o		Home 5 Resider	nce 6 Other (Spe	cify)
	aath. or: After he funer	ation	Vatural 5 ☐ Pending investig	gation	y Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
	rs efter de el Directo	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ined 28e. Place of Inju- building, etc	ury - At home, farm, sti c. (Specify)	reet, factory, office	28f. Location (Str. City or Town,	eet and Number or Ri State)	ural Route Number,
	one nospirate or Autending Priysician: within 24 hours efter death. To the Funerel Director: After this certifica completely filled in by the funeral director. I	edicai	29a. Certifier 1₽ Certifying (Check only one)  1 Certifying  1 Medical 8	g Physician: To the best of Examiner: On the basis of and manner sta	examination and/or in	h occurred at the time, date and plac vestigation, in my opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner as te and place, and due	s stated. e to the cause(s)
	To	Σ	29b. Signature and little of certifier			29c. License number	29	d. Date signed (Mont	h, Day, Year)
	41		30. Name and address of person v	who completed cause of d	leath (Item 23a) (Type,	Ridge Roya	d We	itmin	D 21157
	Sta	te	31. Date filed (Month: Day, Year)		ar's Signature		. , , ,	111.11.3	/ ¥
	Registra	ar	.110 30	02010		and I			

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	,,,	1- For State Registrar		nt of Health ar te of Death	nd iviental Hy		2010	23799
Physici Medical Exam		Decedent's Name (First, Middle, Last)     Dynver	Robins	son	1	2. Date of Death Month I July 25, 201	Day Year	3. Time of Death 0850 hrs
		Facility Name (if not institution, give street and number)     Johns Hopkins Hospital		4b. City, Town, o	or Location of Death		4c. County of Death	
Funeral			In yrs. last birtho			8. Date of Birth	(MM/DD/YYYY) 9. Bird Foreig	
Director		215-87-7096 1 M 2 N F Usual Residence of Decedent		Yrs. Months Da	ys Hours Min.	02-23	-10 Co	untry) MD
w any		10a. State 10b. County 10	Do 1 + 3					10d. Inside City Limits
ne Maryland or 28a-f show any fied at once.	Director	MD NA  10e. Street and Number	Balti	10f. Zip Code		10g	g. Citizen of What Cour	1XXYes 2 No
th the M 23a or 2 notified	al Dire	843 N. Collington Ave		2120			USA	
death w or items	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Evaluation Armed Forces? 1 Yes 2 X	ver in U.S.	<ol> <li>Was Decedent of Hi If Yes, specify Cuba</li> </ol>	ispanic Origin? ( Spe ın, Mexican, Puerto R		14. Race - Ameri White, etc. A	can Indian, Black, African
urs after tural", c	d by F	Widowed 4 Divorced if Yes, Give Year or Dates:		1 Yes 2 X No		rk done	Specify: Am e	
\$6 in 72 hou nan "na lical Exp	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Child Child	du	ring most of working life ${ t Child}$			Child	, and a y
21215-0036 suld be filed within 7 Mental Hygiene. marked other than	Com	17. Father's Name (First, Middle, Last)		CIIIId	18.Mother's Name (F	First, Middle, Ma		
2121 uld be fii Mental I marked	To Be	Davonte Robinsor  19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Stre	Yasmin		Jones	Zin Code)
MD nd 2 sho alth and m 27 is	_	Doreen Dotkins-Grandmo	other	843 N. C	ollingto	n Aven	ue Balti	more,MD
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural?, or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State	crematory King	Disposition (Name of ce y or other place) ${\sf Mem} \cdot {\sf Pk} \cdot$		31-10	20c. Location - City or Randall	rown, State stown, MD
Saltin ermit. P epartme mportar ijury or		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		22. Name and Addres	s of Facility Wy	lie Fu	neral Ho	me F.A.
Physician		a. Part I. Enter the lisease, or complications that caused the	e death. Do not e	1638 N. G	ilmor St , such as cardiac or r	reet B espiratory arrest	Baltimore t, shock, or heart	Approximate Interval
/Medical Examiner		failure. List only one cause seach line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence)						Between Onset and Death
		Sequentially list conditions, b. perinatal	cerebra	1 hypoxia-:	ischemia			
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man and transit	EX	events resulting in death) Last Due to (or as a consequence of the death) Last d.	ence of):					
tox 68760, eath certificate be executed at a strending physician and for use as the burial - transit	ledic	d.  XUNPENDED  AMENDED  PI line a-  1F FEMALE:  23c. If yes, outcome	b, 27,p	e rME g910	12/13/10	TT	23d Date of delivery	
certifica	ian/	23b. Was decedent pregnant in the past 12 months?	2	Fetal death 3	Ectopic pregnanc		Month Date of delivery	ay Year
BOX he death the atte	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	5 [	Other (Specify)				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transi	ð	Part II. Other significant conditions contributing to death be	ut not resulting in	n the underlying cause (	given in Part I.	1 Yes	cco use contribute to the 2 No 3 Proba	ne cause of death?  ably 4  Unknown
ords aw requi as been 2 should	Completed					24a. Was an autopsy	prior to co	opsy findings available impletion of cause of
tal Rectian: The l		25. Was case referred to medical	<u> </u>	26 Place	e of Death (Check onl	performe 1 Yes 2		2 No
Vita	To Be	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient	2 🗸 ER/Outp	atient 3 DOA	Other Nursing I	lome 5 Re	esidence 6 Other:	
ion of tending Pl eath. tor: After the funera		27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day,Year)	28b. Tim		ry at Work? 28 Yes 2 No	3d. Describe how	v injury occurred	
Divisi pital or Att ours after de eral Directo	Certification	Suicide Could not be	- At home, farm	, street, factory, office b	puilding, etc. 28	Bf. Location (Street or Town, State	eet and Number or Rura e)	al Route Number, City
Hospita 24 hours Funera		4 Homicide (Specify)  29a. Certifier 1 Certifying Physician: To the best of my kr	owledge, death	occurred at the time, da	ate and place, and du	e to the cause(s	s) and manner as stated	i.
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated.  29b. Signature and title of certifier	ation and/or inve	estigation, in my opinion			d place, and due to the	
		MICH	M	O.C.I		Ì.	July 26, 2010	, 50,, 1001)
Oxpens		30. Name and address of person who completed cause of death Russell Alexander MD. Assistant Medical	,	111 Penn Street,	Baltimore, MD	21201		
	ate	31. Date flied (Mogth, Day, Year) 32. Registrar's S		P				
Regist	IGII	FOIO VOUDO 10.	7					

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			For State	State o	f Marylan	-				and Me			0	220	000
			Registrar  1. Decedent's Name (First, Midd	die Looth		Cer	tificate	of De	eath			Reg. No 20	U	238	
	Physicia	n/	I. Decedent's Name (First, Mildo		-	D				- 1	2. Date of Dea Month <b>July</b>		<b>Ç</b> ar	3. Time of	
	Medic		4a. Facility Name (if not institution	Nora	E.	Rá	agan 4b. City, T	own or Lo	nostion of	f Dooth	_July_	4c. County of		8:00	<b>A</b> M
1	Examin	er	,	dletown Rd	,		· ·	eelan		Death		Balt		·e	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under	1 Year   I	f Under 2		3. Date of Birtl	h	9. Birthp	lace (State o	
	Director		212-05-1629	1 □ M 2 💢 F	96	Yrs.	Months	Days	Hours	Min.	Sept. I	(1, 1913)	Mar	yland	
	d tt	╻	Usual Residence of Decedent  10a. State 10b. Count	tv	10c Cit	y, Town or Lo	cation						1	0d. Inside Ci	ity Limite
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	or 28%		10e. Street and Number	11101 C			10f. Zip (	Code				10g, Citizen of Wh	at Coun		
	vith the 23a c	al	20329 Middl	etown Rd.				21053				USA	iai ooan		
	eath v	by Funeral Director	11. Marital Status	12. Was Dece	dent Ever in U.S		Vas Decede	nt of Hispa	anic Origi	in? (Specif	fy Yes or No-	14. Race -	America	an Indian,	
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Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Maneral Service	Ligensee		22	. Name and 10	Ackest 050 Y	ซีพีรีซี ork	n Fur Rd. 1	neral H Towson,	Home, Inc Md. 212	04		
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Division of Vital Records,	to the hospital or Attending Prhysician; the law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending placempleted filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director.	Certificate:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide deter	28e. Place	of Injury - At hong, etc. (Specify	me, farm, stre	et, factory,	office		28	f. Location (S City or Town	treet and Number n, State)	or Rural	Route Numb	oer,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Jack Cusick Randles July 29 2010 7:50 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Brightview Assisted Living Harford 9. Birthplace If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) (State or Foreign **Funeral** Country) Months Days Hours 1 🖾 M 2 🗆 F Yrs. 415-22-6497 85 Director Jan. 12. 1925 <u>Georgia</u> Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Modical Examiner must be notflied at 1 ☐Yes 2 No Directo Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 624 Locksley Manor Drive 21001 USA by Funeral death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status e filed within 72 hours after dal Hygiene. Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ <u>Chaplain</u> U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be t and 2 should be fill Health and Mental Heem 27 is marked ot Edgar Earl Randles ပ Mary Ellen Cusick traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important: If Item 27 is
any injury or other trau
once. J. Scott Randles / Son 624 Locksley Manor Dr., Aberdeen, MD 21001 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ØCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 8-2-10 Towson, Maryland 22. Name and Address of Facility.
McComas Funeral Home, P.A. Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): requires that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy sate has been signed by the atte page 2 should be detached for Day Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? The law 24a. Was an autopsy performed certificate 2 🗆 No 1 □ Yes 2 2 No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dther (Specify) Hospital: 1 Yes 2 No Assisted Certification: To After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Living 28d. Describe how injury occurred Division Hospital or Attending 1 Natural Injury 5 Pending death. 1 □Yes 2 □ No Director: / investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide after To the Hospital o within 24 hours af To the Funeral D completely filled in 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie Kohert of Dureno 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

31. Date filed (Month, Day, Year)

30201

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ringgold Jessup 05:30AM uli Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death St. Joseph Medical autimore enter DIVISON W If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Days Hours 723-16-9950 10705/192 Baltimore, MD Director 88 Usual Residence of Decedent 28a-f shov mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland sattment of Health and Mental Hygiene. asstraint if firem 23a or 28a-f sho oortant. If item 27 is marked out than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Towson 1 Yes 2XXNo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21204 1 Smeton Place #1103 12. Was Decedent Ever in U.S. Armed Forces?

1 X X Yes 2 \sum No If Yes, Give 1940-4 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 r res, Give Year or Dates. 1940-46 1 ☐ Yes 2xxxNo Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Produce Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nora Estelle Powell James Offut Ringgold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health ar
Important: If item 27 is 807 Chestnut Glen Garth Towson MD 21204 Nancy Walker/ daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 07/31/2010 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 10 cardia disease or condition Medical resulting in death) Du to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transi ute that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 9 Unknown signed by to be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Tes To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 💢 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 7-2810

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.O.

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ICR

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23803 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 25,2010 2223 Soriano Santome July Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Balto. Franklin Square Hospital Rosedale If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Min. Days Hours Country)
Spain Yrs Director 220-42-9602 74 December Usual Residence of Decedent 23a or 28a-f show 10a. State 10b, County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Md. Balto. Nottingham 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 4707 Ebenezer Road USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married "natural", or Completed by 1 ☐ Yes 2 ☐ No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry I Hygiene. other than "r Elementary/Seconday (0-12) Metal Finisher Car Manufacturer and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ഉ Maria Gestido Riobo Jose Santome Gestido Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Aquilina Olga Santome Spouse 4707 Ebenezer Road Nottingham, Md. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 🔲 Burial 2 🗓 Cremation 3 🗌 Removal from State Bayview 7-27-2010 Balto. Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Schimunek Funeral Home 22. Name and Address of Facility -9705 Belair Road Nottingham, Md. 23 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of use on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) MINUTE Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): The law requires that the death certificate be executed the attending physician and ched for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year 1 Yes 2 L 9 Unknown page 2 should be detached Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CANCER Completed 1 Yes 2 No 3 Probably 4 Unknown PULMONARY OBSTRUCTIVE DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' ☐ Yes 2 No Hospital or Attending Physician: To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) 27. D40480 28 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7602 BELAIR ROAD

Registrar
DHMH 17 Rev 7/2009

FERNANDO

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

FERRO MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Corey Sims		1- For State	Sta	ate of Maryla		artment of ertificate of		nd Me	ental H			2011	0 2	23804
Physicia		Registrar 1. Decedent's Nam	ne (First, Middle							2. Date of Dea			3. Tir	me of Death
Medical Examin		Cor	-		ims					Month July 27, 2		Year		034 hrs
				n, give street and nu w Medical Cen			4b. City, Town, Baltimore	or Locatio	on of Death	)	40	County of De	ath	
Funeral		5. Social Security I		6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye	ear If Ur	nder 24Hrs	8. Date of Bi	rth(MM/	NA	Birthplace	e (State or
Director	ĺ	216-31-	9002	1X M 2 F	19	Yrs		ays Hou	urs Min			For	eign Country)	
	ŀ	Usual Residence o	f Decedent											
w any		10a, State	10b. County			, Town or Locati								Inside City Limits  XYes 2 No
yland a-f she	핡	MD 10e. Street and Nu	mber	NA	В	altimo	re 10f. Zip Code				IOq. Citi	zen of What C		<u> </u>
he Ma or 28	Director			en Aven	ue		2121	4			og. om	USA		
with t ns 23a be not		11. Marital Status		12. Was Dec	edent Ever in L		s Decedent of H	lispanic C			)-	14. Race - Am	erican In	dian, Black,
death	Funeral	1 X Never Marri		1 Yes	2XX No		es, specify Cub			Rican, etc.)				ican
s after rral", niner	잙	3 Widowed		orced If Yes, Give Yea or Dates: ify only highest grad			Yes 2 N					Specify: A		ican
2 hour	Completed	Elementary/Sec		College (1			ost of working li				TOD. P	and of Busines	s/industr	у
036 ithin 7 in than r than fedica	ᅙ	11th	Grade	NA		Stud	lent				H	arbor	Cit	. у
filed w Hygie d othe		17. Father's Name								(First, Middle,				
212' ald be Mental marke	o Be	Cyril  19a. Informant's Na		Sims	lothor	19b. Mailing	Address (Stre		mber or F	,		Jeffer		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time X7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	7			Jeffer		2.1	Ever					•		
re, Fred I and Freath Free free free free free free free free		20a. Method of Dis	position	3 Removal fr	20b.	Place of Dispos crematory or oth	ition (Name of c	emetery,		Date	20c. l	Location - City	or Town,	State
Pages Pages nent of			Other Sp			ing Men	n. Pk.			3-04-10				
Salti ermit. Separtn mport	Ī	21. Signature of Fu	neral Service I	icensee	*		ame and Addre							
Physician	1	23a, Part I, Enter th	ne disease, or	complications that c	aused the death	6.3 Do not enter th	88 N. (	Gilm such as	or S	treet	Ba est sho	<u>ltimor</u>		ID 21217 proximate Interval
/Medical		failure. List on	ly one cause					,			,			tween Onset and Death
Examiner	1	Immediate Cause ( or condition resulting			consequence								+	
	_	Sequentially list co		b. Due to (or as a	consequence of	vfl·							+-	
-		cause. Enter Under (Disease or injury to	erlying Cause	С.										
inst de Lo	Z	events resulting in	death) Last	Due to (or as a d.	consequence of	of):								
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.  The Juneral Director: After this certificate has been signed by the attending physician and apletely filled in by the funeral director, page 2 should be detached for use as the burial - transit	edical Examiner	UNPENDED		AMENDED										
760, cate be physici the burn		IF FEMALE:	prognant in the		outcome of preg	nancy					230	I. Date of delive	ery	-
30x 6876 death certificate e attending phy I for use as the b		23b. Was decedent past 12 months		I I TIME D	irth ant at time of de	ooth -	al death 3 ner (Specify)	Ector	pic pregna	ncy		Month	Day	Year
Box 6876  • death certificate the attending phy ed for use as the	Physician/M	1 Yes 2 1	No 9 Unki	nown 9 Unkno	own	3 <u></u> 0"	ler (Specify)							
that the d		Part II. Other signi	ficant condition	ons contributing to	death but not r	esulting in the u	nderlying cause	given in I	Part I.			use contribute		use of death?
IS, P.C quires that en signed uld be dets	Completed by							-		24a. Was				findings available
tal Records, cian: The law requirecertificate has been sector, page 2 should	틸									autop			o complet	tion of cause of
I Re		25. Was case refer	red to medical	1			26 Plac	e of Deat	th (Check o	1 Yes	2 N	1 🗸	Yes	2 No
Vital ysician his certi director	0 0	examiner?	2 No	Hospital: 1	npatient 2 🗸	ER/Outpatient		Other 4			Resider	nce 6 Oth	тег	
ding Phy. After th	- h	27. Manner of Deat		28a. Date Jul 27, 2	of Injury Day Year)	28b. Time of Ir		ury at Wo		28d. Describe I Subject was				
ivision or Attend after death. Director:	a l	1 Natural 2 Accident	5 Pendi Invest	igation		0010 hrs		Yes 2	<b>Z</b> No					
Division of Vital Records, P.O. ital or Attending Physician: The law requires that the fare death.  Tal Director: After this certificate has been signed by lled in by the funeral director, page 2 should be detacted.		3 Suicide	6 Could	not be	of Injury - At h Sidewalk	ome, farm, stree	t, factory, office	building,		28f. Location (\$ or Town, S 5100 Harford				ute Number, City
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ן כ	4  Homicide  29a. Certifier 1		vsician: To the bes		ge, death occurr	ed at the time.	date and r						
To the He within 24 To the Fu completed				niner: On the basis of and manner st	of examination a									e(s)
HSHO	Ĕ	29b. Signature and	title of certifier				29c. Licen		er			Date signed (N	fonth, Da	ıy, Year)
		Yunaly	erthall.	MO			0.0	.M.E.			July	27, 2010		
4		30. Name and add Pamela E. S	· ·	who completed caus  O Assistant I	e of death (Item Medical Exa		Penn Stree	et, Balti	more. M	ID 21201				
Stat	e i	31. Date filed (Mg)						, 50.11						
Registra	ar	JUL 3	U ZUIU	Lenua	gistrar Signati	CALLER								

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Robert Stuckey :27 A.M 2010 /Medical 4a, Facility Name (If not institution, give street and number) 4c. Counfy of Death Town, or Location of Death Examiner ea are timor Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 250-28-2082 Months Days Hours Min. **★**□ M 2□ F Director 88 21,1922 S.Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c, City, Town or Location 10a, State 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at N/A Baltimore Y☐Yes 2☐No Director Maryland 10e. Street and Number 3902 Greenspring Avenue 10f. Zip Code 10g. Citizen of What Country? 21211 USA Funeral [ 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ➡No Specify: ۾ Spec Black 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Custodian Bethlehem Steel <u>3rd grade</u> is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Stuckey Mattie Allen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health s Important: If Item 27 is any injury or other tracents. Crystal Weaver/Granddaughter 5205 Denmore Avenue Baltimore,MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State Mt.Zion Cemetery 7/31/10 Lansdowne, Maryland 4 Donation 5 Dother (Specify) ^{22. Name and Address of Facility}Chatman-Harris FuneralHome 5240 Reisterstown Rd Baltimore,MD 21215 21. Signature of Funeral Service License ar 23a. Part I. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart froure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arterioscleratio disease or condition resulting in death) propery Inknown Due to (or as a consequence of): Sequentially list conditions, Examiner it any leading to impedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed □Yes 2 **Z**No 25. Was case referred to medical

Physician /Medical **Examiner** 

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The certificate | funeral director. After this

1∐Yes 2 No

5 | Pending

3 0 2010

investigation

determined

6 ☐ Could not be

27. Manner of Death

Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A

Division of Vital Records, P.O. Box 68760,

State

Certification: To

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ryenn

1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of Injury (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST. Date filed (Month, Day, Year)

900 Caton Manes 32. Registrar's

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23806 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ULY 24. 2010 540M **Physician** Annabell Saunders /Medical MA 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/ABaltimore Levindale If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, NOV • 4 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 220-14-2710 1 □ M 2 ⋤ F , 1908 101 Nov. South Carolina Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Baltimore 10d. Inside City Limits 10b. County N/A Maryland 1√ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1204 Eutaw Place #A 21217 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status , White, etc. Black 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: \$ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Hospitals Elementary/Secondary (0-12) College (1-4or 5+) Practical Nurse 11th grade 18. Mother's Name *(First, Middle, Maiden Surname)* Fannie Grunstrop 17. Father's Name (First, Middle, Last) Be William Saunders ဥ 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) 5920 Cross Country Biva Baltimore, MD 21215 19a. Informant's Name/Relationship (Type, Print) Wilhelmina Watts/Cousin 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation Dundalk, Maryland 3 Removal from State 7/30/10 Trinity Cemetery 4 Donation 5 Other (Specify) Harris Funeral Home Baltimore, MD 21215 21. Signature of Funeral Service Licens 22. Name and Address of Facility Chatman own Rd Reisterstöwn 5240 Terro 23a. Part1. Inter the useas of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearth liture. List only one cause on each line. Im relate Caus Final disease or control resulting in death) We **Physician** 6 month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physiclan and for use as the burial-tran Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 TYes 2 No 3 Probably Completed √24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has t page 2 sl perform 1 Yes 2 certificate 25. Was case referred o medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA ဥ 1 Inpatient After this 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

the Hospital or Attending 24 hours after death. within 24

State

Registrar

DHMH 17 Rev 1/2001

30. Name and ad

29b. Signature and title of certifier

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

eluelere au Belpone IV 21211

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylar	•	artment of F tificate of L				0 23807
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)		Sda	nowich		2. Date of De Month		3. Time of Death 72:14 PM
	Examin		4a. Facility Name (If not institution, give street The Johns Hopkins Hosp	oital		4b. City, Town, or Baltimore	City		4c. County of	
	ineral rector		5. Social Security Number 213-30-1743  6. Sex Usual Residence of Decedent	2 G F 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	th ay, Year) 24, 1933	D. Birthplace (State or Foreign Country)  Maryland
Maryland	ef show	tor	10a. State 10b. County MD Harfor		ity, Town or Lo	Forest	Hill			10d. Inside City Limits 1 ☐ Yes 2XXIo
י with the	3a or 28a t be notif	al Director	10e. Street and Number 2035 Colgate Cir	cle	-	10f. Zip-Code 21	050		10g. Citizen of Wha	at Country?
aryiand 21213-UU36 should be filed within 72 hours after death with the Maryland nd Mental Hygiene.	is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	y Funeral	1 Never Married 2 Married	Was Decedent Ever in U Armed Forces? 1X Yes 2 ☐ No If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2√√No	ispanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	- 14. Race - Black, Specify:	American Indian, White, etc. White
15-0036 172 hours aft	"natural", adical Exa	leted by	15. Decedent's Educati (Specify only highest grade co	Year or Dates: on	16a. Deced	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of wo	orking	16b. Kind of Busin	ness/Industry
d Z1Z filed withii Hygiene.	ther than nt, the Me	<b>Completed</b>	Elementary/Secondary (0-12)  1 2  17. Father's Name (First, Middle, Last)	College (1-4 or 5+)		aster P.	lanner	ame (First, Middle	Balti Cit	
ryland nould be file I Mental Hy	narked o	To Be	John Sda		10h Mailir	an Addraga (Straat	Ar	na Roz		de Zio Costo)
d 2 th	F ==		Annette Schnowich - Spo	use	203	5 Colgate C		rest Hill,	Maryland 2	1050
Dallimore Demit. Pages 1 Department of H	Important: If item 2 any injury or other once.		20a. Method of Disposition  1	oval from State	Place of Dispo cemetery, cren Carcens	sition (Name of natory or other plac OF Falth Ery	e) 7/31.	Date /2010	20c. Location - Cit	ty or Town, State
parit. Departr	Importa any inju once.		21. Signature of Funeral Service Licensee	Spals	° 22	Name and Address Evans Funs	ss of Facility Eral Chape	el and Cren	ration Servi , Maryland 2	ces — Bel Air
Phys	ician		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one call mmediate Cause (Final	ons that caused the deat	. ^	er the mode of dyin	g, such as cardia	ac or respiratory a		Approximate Interval Between Onset and Death
/Me	dical niner		disease or condition resulting in death)	Due to (or as a consec	quence of):	<i>ro</i> lionus	opaciu	4		
ted	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (Stras a consec	quence of):					
e be executed	ohysician and the burial-transit	dical Ex	that initiated events c c c d	Due to (or as a consec	quence of):					
certificate	nding phy use as th	sician/Med	23b. Tras decedent pregnant	If yes, outcome of pregn. 1  □ Live birth 2  □ Feta		Ectopic pregnancy			23d. Date o	of delivery
the deat	y the atte	5	1 Yes 2 No	4 Pregnant at time of c		Other (specify)			Month	Day Year
quires that	uld be del	ed by P	Part II. Other significant conditions contrib	uting to death but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did t		ute to the cause of death?  Probably 4 Unknown
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.	e has bee	Completed					<del></del>	24a. Was a autop perfo 1  Yes	prio prior dea	re autopsy findings available or to completion of cause of tth?  Yes 2 \sum No
sician:	director, p	To Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ★ No	oital: 1 <b>X</b> Înpatient 2 □	ER/Outpatient	. 3 □ DOA Othe		ath (Check only or		
ding Phy	Arrer this funeral of		27. Manner of Death  1   Natural  5 □ Pending  1  Accident investigation	8a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at		how injury occurred	
al or Atter	d in by the	Certification:	2 Cuioido 6 Could not bo	8e. Place of injury - At ho building, etc. (Specify		eet, factory, office	30//	28f. Location (a		or Rural Route Number,
e Hospita 24 hours	e runera		29a. Certifier (check only one)  1 **X* Certifying Physicia 2 ** Medical Examiner:	n: To the best of my kno On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the time vestigation, in my op	ne, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) and mann date and place, and	er as stated. d due to the cause(s)
To the	ф 6 6 6 6 6 6 7 6 7 7 7 8 7 8 7 8 7 8 7 8		29b. Signature and title of certifier	10		29c. License	number		29d. Date signed (N	
10x	\		30. Name and address of person who complete the Boundary A. He		m 23a) (Type,			North Ma	1	
	Stat Registra	<b>-</b>	31. Date filed (Month, Day, Year)	32. Registrat's Sign	ure K		600	MOLUI WO	me or, Dalli	more, MD, 21287

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					. 1.11.77	Č	ertificate of	Death				201	U	23808	<u>ქ</u>
	Physicia		1. Decedent's Name (First, Middle  Nelinda U	ntalan Saj	or					2. Date of De July 2		[®] /010 [™]	ear	3. Time of Death 9:50 A.	6.4
	Medic Examin		4a. Facility Name (if not institution, Gilchrist Hosp	, give street and number)			4b. City, Town, o		of Death	bury .	-	c. County of Ba	Death L <b>tin</b>		
	Funeral		5. Social Security Number	6. Sex 7. Ag	je (In yrs. I	ast birthday,	) If Under 1 Year	If Under		8. Date of Bi	rth <b>Tu T</b> x		. Birtho	lace (State or Foreic	
1	Director		473–54–9594 Usual Residence of Decedent	1 □ M 2\C\t	69-	5 <b>7</b> Yrs.	Months Days	Hours	Min.	(Month, Da	ay, Year) 3 1	943	Phi	lippines	_
	land show d at	호	10a. State 10b. County		10c. Cit	y, Town or L	ocation						11	Od. Inside City Limit	s
	e Mary 28a-f notifie	irec		timore			Hunt Va	alley						1 🗌 Yes 2 🔀 N	10
	s 23a or nust be r	<b>Funeral Director</b>	10e. Street and Number 13031 Jerome J	Jay Drive			10f. Zip Code 2	1030			_	ted St Ameri		try? S	
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	11. Marital Status 1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	If Van Cive		S. 13	Was Decedent of If Yes, specify Cub	an, Mexica	n, Puerto F	cify Yes or No- Rican, etc.)		14. Race - A Black, V Specify:	America White, e		
15-(	72 hou n "natu fedica	nplet	(Specify only highe	nt's Education est grade completed)		(Give	edent's Usual Occu e kind of work done DO NOT use retired	during mos	st of workir	ng	16b. I	Kind of Busin	ess Ind	ustry	
212	within giene. er tha		Elementary/Seconday (0-12)	College (1-4 or	5+) <b>4</b>	iiie.	owner	,			Bri	dal Sh	nop		
Baltimore, Maryland 21215-0036	d be filed Mental Hyg arked oth tic event,	To Be	17. Father's Name (First, Middle, L Felipe Untala	,				18. Moth		(First, Middle, a Sarre		Surname)			
<b>√</b> lar	and 2 should be fil Health and Mental em 27 is marked ther traumatic ev		19a. Informant's Name/Relationsh			1	ling Address (Street								
e,	and 2 Health tem 2		Enrique E. Sajo  20a. Method of Disposition	or 11 / spou	_		031 Jerome	∋ Jay ⊹				LILEY,			
Ē	Page 1 nent of I ant: If it		1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other (S		1 0	emetery, cre	ematory or other pla uneral C	iape!	July 201	ື31 <b>,</b> 0	l		-	, Marylan	ıd
Balt	permit.   Departn Importa any inju once.		21. Signature of funeral Service	Cento	er, P.A.	7									
			23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that caused	d the deat	h. Do not en				Timoniu respiratory ar		aryland	210	Approximate	_
- F	h sician/	8 4	Immediate Cause (Final disease or condition			CARC	INOMA	of un	VENO	UN FA	cim.	ARY		Interval Between Onset and Death Mo 7/5	
red.	Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):						,			
	sit sid	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	ience of):									
			Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as	a consequ	ence of):							+		_
		dical		d									-		_
09/89	sertifice Iding p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	ncy						004 D-4-	E aladio a		
. Box	requires that the death certificate be been signed by the attending physic should be detached for use as the bu	Physician/Medical	in the past 12 months?  1  Yes 2 No 9  Unknown	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown			☐ Ectopic pregnan☐ Other (specify) _	су				23d. Date of Month		y Day Year	
л О	that the	by PI	Part II. Other significant condition	ns contributing to death b	ut not res	ulting in the	underlying cause gi	ven in Part	I.	23e. Did t	obacco	use contribut	te to the	cause of death?	
rds,	equires een sig rould b	eted	BREAST CANCER					_		1 🗆	Yes 2	No 3	Prob	ably 4 🗆 Unknow	n
ຮຸ	S 00 01 1	Completed					_			24a. Was auto perfo			to con	sy findings available pletion of cause of	
ř m	sician: The la certificate ha irector, page 2		25. Was case referred to medical	1			26. P	lace of Dea	th (Check	1 L Yes	2 <b>X</b> N			No	-1
֓֞֟֟֟֝֟֟֝֟֟֝֟	nysicii nis cer I direct	면 면	examiner? 1 ☐ Yes 2 🕱 No	Hospital:	ent 2 🗆	ER/Outpatie	ent 3 🗆 DOA Oth	or.			dence 6	3 🔏 Other (S	pecify)	Hospice	
on or	ending Path. or: After the funera	Certificate:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investig	ation		28b. Time o injury	worl		.	8d. Describe f	now injur	y occurred			
DIVISION			3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin				reet, factory, office		2	8f. Location (\$ City or Tox			Rural F	Route Number,	
:	ne rrospr in 24 hou he Funer pleted fill	Medical		Physician: To the best of kaminer: On the basis of e. Nurse Practioner: To the											ed.
	Nith To t		29b. Signature and title of certifler		) _		29c. Licens		_			ite signed (Me			
			30. Name and address of person w	/ho completed cause of d	eath (Item	23a) (Time	Print)	1395			Ju	14 26	, 20	710	_
	6V		DANIEUE DEBER	MAN, MD 6	7011	VEHA	cies st, 8	MITE	4105	BALT	Im	The in	10	21204	
	State Registra	e	31. Date filed (Month, Dav, Year)	32. Registra	's Signat	are	,								

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State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Ma	iryiaria / L	Certifica	ate of L	Death	Wierkar 11	Reg. N		23809
	Physicia	n/	1. Decedent's Name (First, Middle, Last						2. Date of D	eath		3. Time of Death
	Medic	al	Mary Ann S  4a. Facility Name (if not institution, give s	hipley street and number)		4h C	ity Town or	Location of Deat	July		2010 Year	8:25A M
	Examin	er	Somerford Pla				Color			- 1	Howard	
П	Funeral Director		220-10-3243	¬	(In yrs. last birth	rday) If Un Month	der 1 Year ns Days	If Under 24 Hrs Hours Min.		rth ay <i>Year</i> ) 192	3 PA 9. Birth	nplace (State or Foreign ntry)
7	how	ř	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
relyne)	8a-fs	Director	MD Carrol	1			West	tminste	r			1 ☐ Yes 2 <b>※</b> No
ith the A	23a or 2 st be no	ral Di	10e. Street and Number 416 Old Bachm	ang Vall	5g ve	10f.	Zip Code	1157			itizen of What Cou	intry?
at the	tems (	Funeral	11. Marital Status	12. Was Decedent Ev		13. Was Dec		spanic Origin? (S n, Mexican, Puert	pecify Yes or No		USA 14. Race - Ameri	ican Indian,
3036 In affer the	ural", or i	کِ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑  If Yes, Give Year or Dates.	lo		s 2 🔀 No		o Rican, etc.)		Black, White Specify: Wh	
15-C	n "nat Aedica	Completed	15. Decedent's Ed (Specify only highest grad	de completed)		Decedent's U (Give kind of v life. DO NOT I	work done d	ation luring most of wo	rking	16b.	Kind of Business In	ndustry
212 Within	giene. er tha , the N	Col	Elementary/Seconday (0-12)	College (1-4 or 5+ 5 +	)		cher			E	ducatio	n
and a	ed oth	To Be	17. Father's Name (First, Middle, Last)  Clarence Coba	anah Cmid	<u>-</u> L			18. Mother's Na		, Maider	Surname)	
	mark matic		19a. Informant's Name/Relationship (Type			Mailing Addr	oos /Street e	Anna R		or City	er Town State Zin	Code) 21157
ر الم	althar n 27 is ertrau		Margaret Harris		$ter \frac{1}{4}$	12 01	d Bac	chmans	Valley	Rd	.,Westm	inster
Baltimore, Maryland 21215-0036	perimits ago is an a 2 should be more within a hours area death with the waryand perimits ago and 2 should be marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1		20b. Place of cemeter,	Luthe	r other place r Mil	ler 8/	Date 5/2010	We:	ocation - City or T	er,MD
Balt	Departr Importr any inju		21. Signature of Funeral Service License	flhlin	///_	22. Name	and Addres	s of Facility $ F $	letche:	r F	uneral : ster,MD	Home 21157
P	tysician/	0 0	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line.	he death. Do no				or respiratory a	rrest,		Approximate Interval Between Onset and Death VYS
	Medical xaminer		resulting in death)	Due to (or as a	consequence of	f):						
. 7	=	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence of	f):						
8760 × 10 ificate be executed	physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of	f):		· w				
e pe e	ysiciar ie buria	Medical	L	d								
38760 rtificate be	D, 40		IF FEMALE:	20 17 - 1								
Records, P.O. Box 68 The law requires that the death cert	ned by the attending produced for use as	Physician/I	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	☐ Fetal death	3		у		İ	23d. Date of delive	very Day Year
P.O.	ned by e detad	by Pr	Part II. Other significant conditions con	ntributing to death bu	t not resulting in	the underlyin	g cause give	en in Part I.	23e. Did	tobacco	use contribute to 1	the cause of death?
'ds',	s been signe should be o								1 🗆	Yes 2	No 3□ Pro	bably 4 🗆 Unknown
Division of Vital Records, tal or Attending Physician: The law requires		Completed							24a, Was auto perf 1 🗌 Yes		prior to co	ppsy findings available ompletion of cause of 2 🛛 No
ital	certific rector,	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒No	lospital:			Othe	ace of Death (Che			_	7
ISION Of Vital Attending Physician:	ter this neral di	te: To	27. Manner of Death	1 ☐ Inpatier 28a. Date of injury (Month, Day,	t 2 ER/Out 28b. Tir Year) ini		28c. Injury work?	4 □ Nursing F at	lome 5 Res 28d. Describe		Other (Specifing occurred)	<u>» Asst</u> Living
ion tendir	tor: Af the fu	Certificate:	1   Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be			М	1 🗆 '	Yes 2 No				
DIVIS	ours after death. eral Director: After this certific filled in by the funeral director,	- 1	4 Homicide determined	building, etc.	(Specify)				City or To	vn, State		,
e Hosp	within 24 hours after To the Funeral Dire completed filled in b	Medica	29a. Certifier (Check only one)  2 Certifying Physical Examination (Check only one)  3 Certifying Nurse	er: On the basis of exa	mination and/or	investigation,	in my opinio	n, death occurred	at the time, date	and plac	e, and due to the ca	ause(s) and manner stated.
찬 1	with To tl	-	29b. Signature and title of certifier	M	ms		29c. License D565				ate signed (Month,	
	2		30. Name and address of person who co	ompleted cause of dea	ath (Item 23a) (Ty	ype, Print)		0.1	abi- *	(D )	1045	
	3		Harry Li, 8600	Snowden	River	Pkwy	#301	Colun	mbia, N	ID Z	1045	
	Stat Registra		JUL 3 0 2010	32. Hegistfar	s Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Wayne Roger Schreiner July 2010 3:39pm M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5209 Linton Road Carroll Sykesville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min 1 M 2 - F March Day Year) Maryland Director 59 1951 217-48-6821 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Marken Example 1. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Sykesville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5209 Linton Road 21784 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. δ 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X☐ No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Electrician Electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John George Schreiner Elizabeth Irene Felter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Cindy Schreiner (Wife) 5209 Linton Road, Sykesville, MD 21784 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Highlandview Cemetery 7/31/2010 Sykesville, MD HATCHT FUNERAL HOME & CHAPEL PA PO Box 195 Sykesville, MD 21784 21. Signature of Funeral Service Licensee Para Stara 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ation disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Doe to for as a ponsecuence of cause, Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an After this certificate has autopsy performe funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home \(5 \) Residence \(6 \sum \) Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending Natural Accident Suicide Found 15:30 2 No Huna 7/27/10 1 Yes Investigation 24 hours after deatle Funeral Director; completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number & City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 5209 Linton Road TOMP Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year)

State

Herbert

Registrar

29

Manchester Rd Manchester Md

leted cause of death (Item 23a) (Type, Print)

erson J-MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mend #19a Per FH G906 8/02/2010 JH
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2010 24, Stephen Joseph Spencer Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Shady Grove Adventist Hospital Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, ) August 14, 9. Birthplace (State or Foreign Funeral 1 🕅 M 2 🗆 F Months Days Hours Min. Yrs Washington, D.C. Director 219-46-7590 63 Usual Residence of Decedent 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 United States 12505 Village Square Terrace A 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural" 3 Widowed 4 Divorced Specify. Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Computer Engineer Medical other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Joseph Spencer Marvel De Costa Bien 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Daughter Alexa Spencer 7205 Chestnut St., Chevy Chase, Maryland 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 29,2010 Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Has Fr M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Inderlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit Metastatic Lung Cancer that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) s been signed by the serious should be detached 1 ☐ Yes ∠ ☐ g ☐ Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an page 2 s performed Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one)

P.O. Records, Division of Vital

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 certificate funeral director, within 24 hours after death.

To the Funeral Director: After completed filled in by the funer To the l within 2 To the l

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Certificate:

Medical

State Registrar 2210

10d. Inside City Limits

Approximate interval Between Onset and Death

White

1 🗆 Yes 2 💢 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 30 per dvr e905 7-30-10 vt State of Maryland / Department of Health and Mental Hygiene 23812 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7 1:05 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 X M 2 □ F 1273171919 Country) Director 218-05-7325 90 MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔽 No MD BALTIMORE BALTIMORE 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a o Examiner must be Funeral 725 MT. WILSON LANE, #501 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12, Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married 5-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X☐ No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced WHITE traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PROPRIETOR FURNITURE other fled \ Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Mental is marked ၀ SAMUEL STARK **ESTHER** HECKER and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 1 and 2 store of Health a STUART STARK/SON 8517 MEADOWSWEET ROAD, PIKESVILLE, MD or other 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OHEB SHALOM MEM. PK. 7/29/2010 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. ignature Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that calculated the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner My ocardial infarction Sequentiall, list conditions, if any, leading to immediate cause. Enter Underlying Completed by Physician/Medical Examiner been signed by the attending physician and should be detached for use as the burial-transit  $\leq Q$ Cause (Disease or linjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
5 ☐ Other (specify) ____ 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Day Year 1 Yes 2 L 9 Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Myelodysplusia 1 Yes 2 No 3 Probably 4 Unknown Chrisic i Acite Renod insufficient 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has completed filled in by the funeral director, page 2 autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director; After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 은 2 No Other: 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at iniun 5 Pending work? ☑ Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0004701 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2700 Quary Lake Dr. #290 Balto. Md. 21209 31. Date filed (Mo State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9:15amm O' 200 Ellsworth Turner, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Union Memorial **Hospital** <u>Baltimore</u> If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Days Hours 10/21/1941 Maryland Director 220-34-6518 68 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outber than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Maryland Baltimore Middle River 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 6923 Harewood Park Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Pressman Newspaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Paul Ellsworth Turner, sr<u>Evelyn</u> Mary Youkl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21220 Middle River. <u> Marv Louise Turner (Wife)</u> 6923 Harewood Park Road Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Bayview Crematory 7/28/2010 Baltimore City, MD 22. Name and Address of Facility Bruzdzinski Funeral Hom 1407 Old Eastern Avenue Home Maryland 21221 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause or each line. Onset and Deat Immediate Cause (Final Physician/ Schemic cardionero disease or condition ueen Medical resulting in death) Due to (or as a consequence of): Examiner uncontrolled Esque Hally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Medication NON that initiated events Due to (or as a consequence of): resulting in death) Last Certificate: To Be Completed by Physician/Medical neumoni Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital o within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) , M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 F. university Drind

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) **JUL 3 0 201**(

32. Registrar's Signature

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State Registrar	Please			d / Depa		<b>nk. Ensure</b> Health and <i>Death</i>	Mental Hy		Legible.	22015
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60		30. Name and address	s of person who	completed cause	e of death (Item	1 23a) (Type, I	Print)	1-34868	or Pani	07-	Clubs.	2/044
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 1 0 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:40AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3502 Riva Road Davidsonville Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 15, 1 Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Country)
Wisconsi 1**7** M 2 □ F Months **Director** 398-40-8994 67 1943 Usual Residence of Decedent or 28a-f shove notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 ☐ Yes 2X No Davidsonville <u>Maryland AnneArundel</u> 10f. Zip Code ò 10e. Street and Number 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 3502 Riva Road 21035 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Yes 2 □ No If Yes, Give Year or Dates. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) t. Page 1 and 2 should be filed with tment of Health and Mental Hygien rtant: If item 27 is marked other th jury or other traumatic event, the 4 Computer <u>Technican</u> U.S.Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Anton Wafle Mary Walsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda M. Wafle/Wife 3502Riva Road, Davidsonville, Maryland21035 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) ArdentCremation, INC.7-30-10 Hanover, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A michael 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 N 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pendina 🗖 Accident Investigation Suicide 6 Could not be 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🔀 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b, Signature and title of certifier 29c. License numb ame and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month," Day: Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Thomas Leroy Woods 11:46A M July 29 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson <u>Baltimore</u> 5. Social Security Number Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X X** M 2 □ F Months Hours 2/9/1937 Year) 183-28-1821 73 Director Pennsylvania Usual Residence of Decedent or 28a-f show 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland| Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 U.S.A. 6500 Abbey View Way 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc "natural", or þ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Association Elementary/Seconday (0-12) College (1-4 or 5+) C.P.A. Executive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Woods Ruth Frye 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6500 Abbey View Way Towson, Maryland 21212 Andrew L. Woods / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hilltop Serv. Corp. 7/30/2010 Towson, Maryland 4 Donation 5 Other (Specify 22. Name and Address of Facility 21. Signatur Ruck Towson Funeral Home, Inc. <u> 1050 York Road Towson, Maryland 21204</u> 23a. Part 1. Enter the disease, or shock, or heart failure. List o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examin physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 ☐ No led by the a detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.O. I been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 No this certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 X No ဂ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending nours after death.

neral Director: Af
I filled in by the fu 1 Yes 2 No Investigation Accident Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Hospital Medical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 6701 NCHARLES ST, STITE-4105 BALTIMOTES MB 21204 DANIETTE DOBERMAN

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend # 5 per FH 9907 9.24.10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** errietta 2010 4:20AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Fairhaven Sykesville Carroll Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Mar 3, 192 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Days 1□M 2**Z**F Months Hours <del>214-</del>14-0066 89 Yrs. 1921 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show the Medical Examiner must be nutified at MD 1 ☐ Yes 2 ☐ No Carroll Sykesville Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7200 Third Avenue, Apt. C-80 21784 U.S.A. or Items 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 □ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: <u>ک</u> White 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wire Department of Health and Mental Hygienn Important: If item 27 is marked other that any injury or other traumatic event, their once. 10 Own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Parker Cecelia Jarosinski ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) George J. Walters, Sr.-husband 7200 Third Ave, Apt.C-80, Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/2/10 Dulaney Valley Timonium, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. William G. Dau 1050 York Rd., Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical tricular systelic dystenation **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner nding physician and use as the burial-translt Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐ Pregnant at time of death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Mann of Death 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 252010 ULY Elizabeth Barbara Ward /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. JT. AGNES HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 X F Director 219-44-8832 61 09 18 48 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1X Yes 2 □ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a 135 North Monastery Ave 21229 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 💆 No by | Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Black permit. Pages 1 and 2 should be filed within 72 hc
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natur
any injury or other traumatic event, the Medical Is
once. Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Guard lyr Charles Hickey School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James B. Ward Sr. Mary E. Gavnor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Ward-Brother North Monastery Ave, Baltimore, Md 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Murial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify) King Memorial Park 8/2/2010 Woodlawn, Md nature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an has te autopsy performed? page certificate 2 □ No or Attending Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 🗌 Yes 2 🗆 No within 24 hours after death

To the Funeral Director:
completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier

State

Delisia

155AK.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30201

Registrar
DHMH 17 Rev 1/2001

GOOCATON

1003676

AVE BALTIMORE, MO 21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Sarah Wade  $P^{M}$ 21 2010 5:45 Julv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Center Towson Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2X F Days (Month, Day, Year)
Jan 27 Hours Min. 213-30-3046 78 **Director** Georgia Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant; If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore 1 🗶 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3239 Lawnview Avenue 21213 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ XXNever Married 2 - Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Black Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11th Grade New China Inn Domestic Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Frank Wade Madie Lee George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3239 Lawnview Avenue Baltimore, MD 21213 Frank Townes/ Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 🛛 Burial 2 🗆 Cremation 3 🗆 Removal from State Carmel Cem. 7/28/10 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home ller tours 4210 Belair Road Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onse and Death Physician/ disease or condition resulting in death) NON-SMALL Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed fer death. that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CORONAMY ARTEMY DISEASE 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown PERIONERAL VASCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 this certificate 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) #DSPICE Certificate: To 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of After t 28c. Injury at 28d. Describe how injury occurred 5 🗆 Pending ifter death.

Lirector Aff 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours

To the Funeral

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title

Registrar

State

CHARLES STI SUITE 4105 BALTIMORE MD 21204

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DANIEUE DOBERMAN, MO

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2010 Physician/  $\operatorname{July}^{ ext{Month}}$ Patterson Watts Doris Louise 26 1:15 p.mM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Rockville Nursing Home Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Country Alabama (Month, Day, Year) eb. 25, 1934 1 - M 2 X F Days Hours 76 Director Feb. 419-42-7170 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20817 United States 9802 Holmhurst Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Higher Education Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Johnnie Lee Patterson Lena Irene Marty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9802 Holmhurst Rd. Bethesda, MD 20817 Susan W. Buzek (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Aug Date 7, 20c. Location - City or Town, State cemetery, crematory or other place)

Olivet Cemetery 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Mt. 4 ☐ Donation 5 ☐ Other (Specify) Dickinson, Texas 2010 22. Name and Address of FacilitRapp Funeral & Cremation Service 933 Gist Ave. Silver Spring, Maryland 20910 M00982 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Chronic Obstructive Polyoner Duesse Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a dunsequence of) cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year signed by the a 1 Yes 2 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed eral Director: After this certificate filled in by the funeral director, pag 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Tes 2 - No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier MD 00064624

Registrar

DHMH 17 Rev 7/2009

State

SANDEEP

31. Date filed (Month, Day,

Gaithesburg, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHARMA

Year)

743

32. Reg

Summer

			Pleas	se Type or Print					-	,				
			State of Maryland / Department of Hea  State of Maryland / Department of Hea  Certificate of Department of Department of Hea					I Mental Hygiene						
		-	1. Decedent's Name (First, Middle, Last)					Reg. No. 2 3 8 2 2 2 2 Date of Death S. Time of Death						
	Physici		Hildegard Wiencke-Lotz						Month Day Year July 7 2010 10:00					
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death						4c. County of Death					
			Genesis at Kno				rsville	Anne Arundel						
	Funeral		, , , , , , , , , , , , , , , , , , , ,	6. Sex 7. Age (	In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	(Month, Day, Year) Country)						
ü	Director	Director	199-18-4632   15   92   92   15   Sept 24   Usual Residence of Decedent						4, 191/  G	ermany				
5-003b	nyland how		10a. State   10b. County   10c. City, Town or Location   MD   Anne Arundel   Millersvil				-			10d. Inside City Limits				
	ne Ma 8a-f s otifled			Arunder	HITTLE					1 ☐ Yes 2 No				
	be filed within 72 hours after death with the Marylan the Hygiene. dather than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notifiled at	Dire	10e. Street and Number			10f. Zip Code 21108			10g. Citizen of What (	Country?				
	ns 23	Funeral	899 Cecil Ave	12. Was Decedent Eve	er in U.S.	13. Was Decedent of H	Hispanic Origin? (Sp	pecify Yes or No	USA 14. Race - An	nerican Indian,				
٥	after or or iten nlner		1 ☐ Never Married 2 ☐ Marri			If Yes, specify Cub  1 ☐ Yes 2 No	an, Mexican, Puèrto  Specify:	o Rican, etc.)	Black, Wi Specify: W	· ·				
2-003p	ours aural, c	Completed by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	Year or Dates:									
7	"natu "natu edical		15. Decedent (Specify only highes	16a. D	ecedent's Usual Occup Give kind of work done fe. DO NOT use retire	oation during most of work	king	16b. Kind of Busines	b. Kind of Business/Industry					
121	within in interest.	dmo	Elementary/Secondary (0-12) College (1-4or 5+)			orgein lan			educati	ation				
and	e filed value of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of t	a l	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,						
	uld be i Mental   Irked of Itic eve	To B	Wilhelm Lotz			Martha	Mallenk							
Ž	iges 1 and 2 should be nt of Health and Menta If item 27 is marked or or other traumatic ev	·	19a. Informant's Name/Relationship (Type. Print)  Winfield Wiencke – son  19b. Mailing Address (Street ar					Number or Rural Route Number, City or Town, State, Zip Code) Place NW; Washington, DC 20037						
	permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr	1 1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 💆 Other (Sp	3 □Removal from State	20b. Place of D cemetery,	isposition (Name of crematory or other pla		Date	20c. Location - City	or Town, State				
altimor	mit. F Dartme Sortan / Injur		21 Six walling of Funeral State Anatomy Board											
ä	permi Depar Impor any Ir		655 W. Baltimore Street; Baltimore, MD 2120											
	hysician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):											
Š	/Medical Examiner		resulting in death)	Due to (or as a o	consequence of)	10000	<u> </u>							
*	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a o	consequence of)	:								
Ď	eath certificate be executed attending physician and for use as the bunal-transit	Exan	that initiated events resulting in death) Last	CDue to (or as a c	consequence of)									
09/90	certificate be iding physicia ise as the bur	dical	2	d										
×	n certil anding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf 1 ☐ Live birth 2			23d. Date of o	23d. Date of delivery						
_	that the death ed by the atten detached for u	Physician/Medica	in the past 12 months? 1 □ Yes 2 PRo 9 □ Unknown	4☐ Pregnant at tir 9☐ Unknown		3 □Ectopic pregnanc 5 □ Other (specify) □		Month	Day Year					
	w requires that the d been signed by the should be detached	Completed by Pi	Part II. Other significant condition	ns contributing to death but	23e. Did tobacco use contribute to the cause of deat  1 ☐ Yes 2 ☐ N 3 ☐ Probably 4 ☐ Unk.									
cords	law requas been 2 shoul									autopsy findings available				
Ť	The lav	omp							performed? prior to completion of cause death?					
		To Be Co	26. Place of Death (Check only one)											
	Physician: this certific ral director,		1 Yes 2 4 Rursing Home 5 Residence 6 Other (Specify)											
	ing P	on:	27. Manner of Death  1						28d. Describe how injury occurred					
UNISION	Attending r death. ector: After by the funer	icati	2 Accident investig 3 Suicide 6 Could n	Yes 2 □ No	28f. Location (	Rural Route Number								
2	ital or A rs after ral Dire led in by	Certification:	3 ☐ Suicide  4 ☐ Homicide  4 ☐ Homicide  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	To t withi To ti	M	29b. Signature and title of certifier 29d. Date signed (Mor							onth, Day, Year)				
			29b. Signature and title of perfities  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Figistrar's Signature  33. Figistrar's Signature  34. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. June 1. Ju											
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physicia Medic		Decedent's Name (First, N     Gordon		ancis	Wi1z					N	late of Deat	th Day	10 Yea	r	3. Time of Death		
Examin		4a. Facility Name (if not institution, give street and number) Gilchrist Hospice					4b. City, Town, or Location of Death  Towscn				1	4c. County of Death Baltimore					
Funeral Director	r	5. Social Security Number 219–42–7274					If Under 1 Year If Under 24 Hrs. 8. Date of Bi Months Days Hours Min. (Month, Di December			ate of Birth Month, Day Ender 2	) 20, 194	e (State or Foreignaryland					
ryland -f show ed at		Usual Residence of Deceder  10a. State 10b. Co	City, Town or L						10d. Inside City								
th the Ma 3a or 28a t be notif	Funeral Director	Maryland Baltimore					nkton 10f. Zip Code					1 ☐ Yes 2√2					
1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at.	ğ	11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates.				J.S. 13	21111 S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 □ No Specify:						USA  14. Race - American Indian, Black, White, etc.  Specify: White				
in 72 hours e. nan "natur Medical E	Completed	15. De	15. Decedent's Education 16a. D Specify only highest grade completed)						ecedent's Usual Occupation live kind of work done during most of working e. DO NOT use retired)					16b. Kind of Business Industry			
should be filed within 73 and Mental Hygiene. is marked other than aumatic event, the Me	To Be Co	17. Father's Name (First, Mid	dle, Last)	3 Accountant  18. Mother's Name (First								•					
2 should be h and Men 7 is marke traumatic		Joseph S. W:	tionship (Typ									e)					
. Page 1 and 2 s tment of Health s <b>tant: If item 27</b> i jury or other tra		Mrs. Rose M. Wilz (Wife) 116600 York Road Monkton, Maryland 21111  20a. Method of Disposition  1 Disposition 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)								, State							
permit. Page 1 and 2 s Department of Heath Important: If item 27 any injury or other tr. once.		4 Donation 5 X Ott			nt Di		22. Name a	and Addres	ss of Facility	2/201		Timo			cyland 21204		
hysician/ Medical Examiner		shock, or heart failure. Ist only one cause on each line.  Inter Ons											proximate terval Between nset and Death				
siciar bunia	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	f any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events C.														
within 12 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the beautiful to the completed filled in by the funeral director.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ ∀es 2 □ No 9 □ Unknown		02a. If year outcome of prognancy										23d. Date of delivery Month Day Year			
n signed by	호	Part II. Other significant con	W.					bacco use contribute to the cause of death? 'es $2 \square$ No $3 \square$ Probably $4 \square$ Unknown									
cate has bee page 2 shou	Completed			24a. Was an autopsy performed? 1 \subseteq Yes 2 \subseteq No						prior to death	<ul> <li>4b. Were autopsy findings available prior to completion of cause of death?</li> <li>1  Yes 2  No</li> </ul>						
his certific Il director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital:  1  Inpatient 2 ER/Outpa													osphe		
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n 24 hours a re Funeral C	Medical C	29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)  3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)															
withii cong		29b. Signature and little of certifier  29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)															
5×1		30. Name and address of per	CH	Mie	My	670	Print)	v.C	Meli	251	75	W SOI	V	N	7		
Stat Registra		31. Date filed (Month, Day, Ye		32. Re	gistrar's Sign	ature	9										

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July Melvin Luther Yingling 2010 9:05 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Golden Living Center Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 1, **Funeral** 9. Birthplace (State or Foreign 1 🕱 M 2 🗆 F Months Days Hours Year 1925 Director 220-16-1514 85 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Maryland Carroll Westminster 23a or 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1234 Washington Rd. 21157 U.S.A. items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. ŏ þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", 3 XWidowed 4 ☐ Divorced White Completed J Hygiene. other than "natura rent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Merian injury or other traumatic event, the Merian injury or other traumatic event, the Merian injury or other traumatic event, the Merian injury or other traumatic event, the Merian injury or other traumatic event, the Merian injury or other traumatic event, the Merian injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury event injury or other traumatic event injury event injury event injury event injury event injury event injury event injury event injury event injury event injury event injury event injury event injury event injury event injury event injury event injury event injury event injury event injury event injury event injury event event injury event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event ev Elementary/Seconday (0-12) College (1-4 or 5+) retail meat cutter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Luther M. Yingling Viola Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John L. Yingling/ son 4218 Upper Beckleysville Rd., Hampstead, MD 21074 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St Mary's Cemetery 7/28/2010 Silver Run, MD 21. Signatur Menneral Service Licenses 22. Name and Address of Facility Hartzler Funeral Home athorine ( Union Bridge, MD 21791 <u>Broadway</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequent of): Examiner Ore55101 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Live to for as a consequence of: Physician/Medical Exami attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cond resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Vear 2 No the 9 Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) in 24 hours after deam. he Funeral Director: After this ce noleted filled in by the funeral dire 2 No Hospital. Other: ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Dea 28a. Date of injury 28b. Time of Certificate: 28c. Injury a 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

only one) Signat

30. Name and address

e and title of certifier

Registrar DHMH 17 Rev 7/2009 on who completed cause of death (Item 23a) (Type, Print)

32. Red

Destin

strar's Signature

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

-27-2010

<u>Gen</u>ine Consagra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7:49 A M Physician Zimmerman 29 lean 2010 /Medical 4a. Facility Name (If not institution, give street and number) CENTER 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan, 28, 1931 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗖 F 213-28-4049 MD Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ?7 Is marked other than "natural", or items 23a or 28a-f shot traumatic event, the "modesal Exercity or items 23 Baltimore MD 1 Yes 2 □ No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 1025 Spangler Way USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 ∐Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 in and Mental Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Mister Donuts Manager 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hilda Keller James Nace 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sl Department of Health an Important: If Item 27 Is n any injury or other traun 3404 Chesterfield Ave. Balto. MD 21213 Renee Nelson /daughter 20b. Place of Disposition (Name of cemetery crematory or other place)

Baltimore National 8/2/10 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial Cremation 3 Removal from State Baltimore MD Other (Specify) 4 Donation 21. Signature of Funeral Service Linus 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Party. Enter the disease, or com-shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest potension **Physician** 30 minutes /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine The law requires that the death certificate be executed Cause (Discuss or Ir ju that initiated events resulting in death) Last attending physician and for use as the burial-trar Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 🗷 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the by signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No cate has t autopsy certificate 2 **2** No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Records, Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

ern Avenue, Baltimore, MD21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 27 2010 Year JULY MYROSLAW ZOBNIW 10:40p M Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner SEASONS HOSPICECENTER BALTIMORE RANDALLSTOWN 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min 0(3°7") 3°4/1°19 17 93 UKRAINE 212-38-0399 Director Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3501 OLD COURT ROAD 21208 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 XMarried Ş Maryland 21215-0036 1 Yes 2 XNo Specify Specify: Completed 3 Widowed 4 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) should be filed within and Mental Hygiene. LABORATORY SCIENTIST MEDICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ PAVLO ZOBNIW MARIA CHROMIAK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health ANNA ZOBNIW/ WIFE 3501 OLD COURT ROAD, PIKESVILLE, MD 21208 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CEDAR HILL CEMETERY 7/31/10 SUITLAND, MARYLAND 21. Signature of Funer service Licensee ame and Address of Eacility
LLY & ZEILER INC. LTLL 1901 FUNERAL HOME EASTERN AVENUE, BALTO, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Preumonits 10de disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page death? 2 2 🗌 No this certificate ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Pother Specify Hospital 2 140 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 Natural 5 Pending 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu ☐ Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32 B

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23827 1 - State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 09, 2010 13:55 Anamelechi Julius 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04–12–1930 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. 1X M 2 □ F 578-58-7831 80 Nigeria Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c, City, Town or Location 1 ∐Yes 2¶∑No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 228 Tuckerman St. N.W. 20011 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 📉 No Specify: Black If Yes, Give Year or Dates: Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Aid Economics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Anamelechi .Tohn Cecilia Mgbela 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 228 Tuckerman St. N.W. Washington DC 20011 Esther Anamelechi (Wife) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 M Burial 2 ☐ Cremation Removal from State 08/15/2010 Family Cemetery 4 □ Donation 5 ☑ Other (Specify) Nigeria 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. neral Servic 3447 14th St. N.W. Washington, DC 20010 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication shock, or heart ailure. List only one complications are complications. hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Immediate Cause Final disease or condition resulting in death) Preumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

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23a

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Pages 1 and 2 should be filed v nent of Health and Mental Hygie int: If item 27 is marked other i

Department of Health Important: If item 27 any injury or other tr

72 hours after death with

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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traumatic event, the Medical Economics must be notified at

/Medical

10a. State

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attending physician and for use as the burial-transit the signed I page 2 s has certificate director this

funeral

After

To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A completely filled in by the fu

death.

Physician: The law requires that the death certificate be executed

Box 68760.

P.0.

Records,

Division of Vital

Hospital or Attending

Examine Physician/Medical Completed Be ၉ Certification:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Mellit

24a. Was an autopsy perform 1 □ Yes

24b. Were autopsy findings available prior to completion of cause of death?

rmed? 2 **⊠**No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 ☐Yes 2 ☐ No

25. Was case referred to medical examiner's 1 Yes 27. Manner of Death

1 XNatural 2 Accident

5 Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 ☐Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 ☐ Suicide

4 ☐ Homicide

l 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and fitte of certifier

29c. License number D45660 29d. Date signed (Month, Day, Year) 7-12-10

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LN, 124 143C ex

State Registrar

Medical

Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Jak France All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month William Arnold, Sr. Albert 2010 Julv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Allegany 227 Humbird Street If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 ▼ M 2 □ F 59 Director 215-56-7750 11/12/1950 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ Director Examiner must be notified 28a-f MD Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? 23a Funeral USA 227 Humbird Street 21502 items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important If Iten 27 is marked other than "natural", or i any injury or other traumatic awant than "natural", or i à 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Trucking Loader Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Canable Arnold Goldie Valadith Ervin Jesse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 227 Humbird Street, Cumberland, MD 21502 Hazel L. Arnold / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 07/13/2010 Forest Glen Cemetery : Greenspring, WV 4 Donation 5 Other (Specify) gn ture of Funeral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final 14 cinome Physician/ metagrafic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine rany, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, ng physician and as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical been signed by the attending should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Thomas 5 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 sl aw. autopsy performed Yes 2 Bronge the Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No After this certificate funeral director, pag 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) 2 No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work' 1 Yes ithin 24 hours after death.

o the Funeral Director: All

ompleted filled in by the fu death. Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

To the F

complete only one) 29d. Date signed (*Month, Day Year)* **July 12, 2010 June** 12, 2010 29b. Signature and title of certifier D0035674 30. Name and address derson who completed cause of death (Item 23a) (Type, Print) Wanda Simmons-Clemmons, M.D., 621 Kelly Road, Cumberland, MD NLS 21502 31. Date filed (Month, Day, Year) 37. Registrar's Signature State

Registrar

13

JUL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23829 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2010 Mary Ellen Brown 9:10M u 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown Social Security Number 6. Sex Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 1 M 2XX Months Hours Sept 10, Year) 1919 90 219-12-0817 Mary land Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Thurmont 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #6 Clarke Avenue 21788 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates White Specify. 3 Widowed 4 ☐ Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Intake worker Social Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond E. Creager Edith Grace Wiles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne Myers - daughter 16638 Shenham Road, Hagerstown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🙀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Blue Ridge Cemetery 7-17-2010 Thurmont, Maryland 21. Sig a ture of Funeral Service Licensee

Pnysician/ Medical Examiner

Physician/

Medical

Director

Funeral

Completed by

Be

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**Examiner** 

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M. dical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

cate: To Be Completed by Physician/Medical Examin

Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate be executed

certificate has been si rector, page 2 should I

To the Funeral Director: completed filled in by the

_	Maron Ga	nille Co.		1 Opossumtown	ı Pike, Fr			
	23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Due to (or as a correct	quence of):	e mode of dying, such as ca	irdiac or respiratory a	rrest,	Approximate Interval Between Onset and Death	
Completed by Physician/Medical Examiner	S prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consect		Carcionyo	palmy			
Iysician/ Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	Bc. If yes, outcome of pregn  1  Live Birth 2 Fe  4  Pregnant at time of  9 Unknown	tal death 3 🗌 Ec	topic pregnancy her (specify)		23d. Date of a	delivery Day Year	
neted by Fi	Part II. Other significant conditions cond Presumonia	tributing to death but not re	sulting in the under	rlying cause given in Part I.			to the cause of death?  Probably 4 Unknown autopsy findings available	
					— auto	ppsy prior t formed? death	o completion of cause of	
מ	25. Was case referred to medical examiner?							
	1 ☐ Yes 2 No	ospital: 1	ER/Outpatient 3	DOA Other: 4 I Nurs	ing Home 5 ☐ Res	idence 6  Other (Sp.	ecify)	
oei uiloate.	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?  M 1 Yes 2 N		how injury occurred		
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, f	factory, office	office 28f. Location (Street and Number or Rural Route in City or Town, State)			
Medical	(Check 2" L. Medical Examine	er: On the basis of examination	on and/or investigati	red at the time, date and pla on, in my opinion, death occu n occurred at the time, date ar	rred at the time, date	and place, and due to th	e cause(s) and manner stated	
	29b. Signature and title of certifier	7 ( .7		29c. License number	3932	29d. Date signed (Mor	nth, Day, Year)	

State Registrar

12

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hmodel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 1 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Emily Baker 2010 9:50 AMM Marv Ju1y14 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Caroline Denton The Gables If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2√ F Months Days Maryland 93 1916 <u>215-18-4262</u> Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 □ No Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21629 701 South Fifth Avenue United States of America 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Armed Forces?
1 ☐ Yes 2 🕱 No 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🎦 No If Yes, Give Year or Dates: Specify. Specify: 3 Widowed 4 Divorced Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria worker/Domestic School/other homes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Esther Poole Lewis Beniah Baker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Alan Baker Nephew 9524 Nightsong Lane, Columbia, Maryland 21046 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/17/2010 Denton, Maryland 4 Donation 5 ☐ Other (Specify) Denton Cemetery 21. Signature of Funeral Service Line 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part !!. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No 26. Place of Death (Check only one) assisted living Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6X□Other (Specify)facility 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 2 🗌 No

Examiner The law requires that the death certificate be executed burial-tran P.O. Box 68760. the attending physician hed for use as the buris signed by the a d be detached for of Vital Records, has this certificate To the Hospital or Attending Physician: After thi

Physician

/Medical

**Physician** 

Examiner

Director

Funeral

Completed

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Physician/Medical

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Certification: To

Medical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" ~-." any fijury or other traumatic event.

/Medical

IF FE	EMALE:	
23b.	Was decedent pregnant	
	in the past 12 months?	
	1 ☐ Yes 2 ☐ No	
	9 Unknown	

25. Was case referred to medical examiner? 

27. Manner of Death 1 Natural 2 Accident

3 Suicide

4 Homicide

5 ☐ Pending investigation 6 ☐ Could not be

1 ☐ Yes 28e, Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Denton, Maryland 920 Market Street, s Sides, M ed (Month, Day, Year) M.D.

State Registrar



DHMH 17 Rev 1/2001

within 24 hours after common to the Funeral Director; After manufactor with the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of th

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 23831 Reg. N2 0 1 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MIRIAM LORRAINE BLY JULY 10 2010 10:43 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 120 LONG POINT ROAD STEVENSVILLE QUEEN ANNE'S Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 **X** F Months Days Hours Min MARCH 27 88 Director 219-12-2507 MARYLAND Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits ms 23a or 28a-f s must be notified MARYLAND QUEEN ANNE'S 1 ☐ Yes 2 X No STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 120 LONG POINT ROAD 21666 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

Yes 2X No Examiner 14. Race - American Indian, 10. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: WHITE "natural", 3 X Widowed 4 Divorced Specify: Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) the CAFETERIA ATTENDANT SCHOOL BOARD Be 17. Father's Name (First, Middle, Last) .. Page 1 and 2 should be filed tment of Health and Mental H rant: If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) WALTER CUTSAIL ANNA STONE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6504 WILSON ROAD, FRIENDSHIP, MARYLAND 20758 JOHN BLY/SON : If item 2 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State RESTHAVEN MEMORIAL Important: I any injury of FREDERICK, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME, 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death
YEARS CHRONIC OBSTRUCTIVE LUNG DISEASE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner **ASTHMA** Sequentially list conditions, it is a sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Examine We to for as a not sugar new of, Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Month Year 9 Unknown 9 I Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION, MORBID OBESITY, MELANOMA 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown director, page 2 should **DEGENERATIVE JOINT DISEASE** 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has I autopsy performed? Yes 2**X** No After this certificate 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ▼ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

JAMIE HARMS M.D.

31. Date filed (Month, Day, Year)

D41339

115 SALLITT DRIVE, STEVENSVILLE, MARYLAND 21666

7-12-2010

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	ase Type or Pr			Indelible Inloartment of F		-		_		
	•	For State Registrar		State of N	iai yiai		ertificate of L				2010	23832	
Physicia Medic		1. Decedent's Name	•	BUCK	EL				2. Date of De			3. Time of Death	
Examin				n, give street and number)				r Location of Death	· /		4c. County of Death Anne Arundel		
Funeral		Mandrin 5. Social Security No		ce House	ge (In yrs. I	ast birthday	Harwo If Under 1 Year Months Days	9. Bir	thplace (State or Foreign				
Director		141-22-7 Usual Residence of		1 <b>X</b> 2 □ F	82	2 Yrs. Months Days Hours Min. (Month, DAPRIL					928 Ne	w Jersey	
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or 28a- notifie	Direc	10e. Street and Num		ALUIGEL	Severna Park					10a C	itizen of What Co	1 🗆 Yes 2 🗶 No	
s 23a o	Funeral Director	242 Cha	rita W	ay	21146						USA		
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urs afte :ural", o		3 🏹 Widowed ⋅	4 Divorced	If Yes, Give Year or Dates.		971	1 ☐ Yes 2 🔀 No	Specify:			Specify: W	nite	
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d 2 should aith and M 27 is ma r trauma		19a. Informant's Na Kathleen		hip (Type, Print) r / daughter	=		iling Address (Street a						
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I firem Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 X Burial 2 4 Donation	☐ Cremation	3 Removal from State		emetery, cr	position (Name of ematory or other place cans cemet	ery July	Date 12,		ocation - City or		
ermit. F epartm nporta ny injui		21. Signature of Fu					22. Name and Addres					uneral Home	
<u>~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ </u>				r complications that cause			<u>195 Ritchi</u>	e Hwy.	Seve	erna	Park,	MD 21146 Approximate	
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Medical Examiner	iner	resulting in death)		Due to (or as	a consequ	uence of):							
		b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):											
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ate be e	edical												
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta at time of	al death 3	☐ Ectopic pregnand☐ Other (specify) _	су	23d. Date of de Month	Date of delivery Month Day Year			
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Hospi 24 hou Funer eted fill	Medical	(Check 2	Medical I	Physician: To the best of Examiner: On the basis of Nurse Practioner: To the	examinatio	n and/or inv	estigation, in my opinio	on, death occurred a	t the time, date a	and place	e, and due to the	cause(s) and manner stated	
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle_Last) 2. Date of Death Physician/ NDREW 0/32 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 15 Severndale Road Severna Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Oct 12, 1 9. Birthplace (State or Foreign Country) New York Social Security Number 7. Age (In vrs. last birthday, **Funeral** 1**.** M 2 □ F Days Hours Months Director 48 070-54-3024 1961 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD Anne Arundel Severna Park 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 23a 21146 15 Severndale Road USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 X Married ٥ þ Yes 2 No White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 'natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than " filed within 7 al Hygiene. d other than Elementary/Seconday (0-12) College (1-4 or 5+) Architect Architecture 5+ Be permit. Page 1 and 2 should be filed
Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other there 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Marlyn Plude Dana Bray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Severndale Road Severna Park, MD 21146 Karen Bray / wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) July Metro Crematory, INC. Baltimore, MD 2010 21. Signature of Juneral Service Licenses Barranco & Sons P.A. Severna Park Funeral Home 495 Ritchie Highway Severna Park, MD 21146 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Doset and Doath Immediate Cause (Final BRAIN Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1  $\square$  Yes 2  $\square$  No 3  $\square$  Probably 4  $\square$  Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No 4 Nursing Home 5 Residence 6 Other (Specify, ည 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined Medical Decritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 23834 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 030 ALICE IVORINE BAKER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ALLEGANY WESTERN MD REGIONAL MEDICAL CENTER CUMBERLAND 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign Country)
FST VIRGINIA Days Hours Min. 1 ☐ M 2 💢 F Director 219-03-9555 Yrs 93 Usual Residence of Decedent or 28a-f show e notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD ALLEGANY CUMBERLAND 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be Funeral 10301 CHRISTIE ROAD 21502 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. <u>م</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🟋 No Specify. Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th PRODUCTION FACTORY WORKER CELANESE FIBERS CORP. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta Important if fem 27 is mark--any injury or ----ပ PHILLIP WILLIAM TALLMAN SARAH EMMA POLING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BONNIE CARNEY / NIECE 78 ELEANOR STREET, LAVALE, MD 21502 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) RESTLAWN MEML.GARDENS 07/20/2010 LAVALE, MD Signature of Funeral Service License 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 23a. Part 1. Entertile disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death Physician/ neumonla disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ō in the past 12 months?
1 Yes 2 No 4 Pregnant a Day Pregnant at time of death 9 Unknown P.O. I signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy performed Yes 2-10 prior to completion of cause of death? page 2 No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Yes 2 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 🔊 Natural (Month, Day, Year) injury 5 Pending work? 24 hours after death. Funeral Director: A 2 🗆 No M 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State

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only one)

29b. Signature and title

31. Date filed (Month, Dav. Ye

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Apartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Dou 3328 0

Ave. Cumberland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23835 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Dav Year Month Burton Chervl Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 - M 2 7 F 52 Director 213-80-0738 09/14/1957 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 14809 Stonegate Terrace 20905 USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed White Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry anould be filed within 72 on of Health and Mental Hygiene.
If item 27 is marked other than "n. or other traumatic event (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Home Be permit. Page 1 and 2 should be filed Department of Heath and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorsey Wayne Robinson Neva Mae Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 14809 Stonegate Terrace, Silver Spring, MD 20905 James H. Burton, III / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Restlawn Mem. Gardens 07/09/2010 LaVale, MD 4 Donation 5 Other (Specify) ig atule of Funeral Service Line 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, METASTATIC LUNG CANCER disease or condition MONTHS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy been signed by the attershould be detached for in the past 12 months?

1 Yes 2 No 4 Pregnant
9 Unknown Day Year Pregnant at time of death 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed? certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 **X**No Other: မြ 1 Tes 1 Nation 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending death Accident Investigation Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined 24 hours a 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the lawithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

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Stein, D.U.

13 2010

31. Date filed (Month, Day, Year)

JUL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18101

Registrar's Signature

PRINCE PHILIP

H0065661

DR

OLNEY

MD

2010

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	_	State of M	arylan	id / Depa <i>Cei</i>	artment <i>tificate</i>	of H	lealth and Death	d Mer	ntal Hyg R	ien _{eg. N}	e2011	0	23836
	Physici		1. Decedent's Name (First, Mid Janis	dle, Last,		Bebri	S					Date of Deat	h		r	3. Time of Death
4	Medi		4a. Facility Name (if not instituti	on, give s				4b. City, To	wn, or	Location of Dea		uly 13	_	c. County of De		9:19 р м
~	·- <u>-</u>		Holy Cross Ho  5. Social Security Number							Spring				Montgo		
۱	Funeral Director		129-26-1892 Usual Residence of Decedent	6. Sex	7. Ag	e (In yrs. Ia	ast birthday) Yrs.	If Under 1 Months (	Year Days	If Under 24 Hr Hours Mir		Date of Birth Month, Day, pt • 10	Year)	1921 f	Birthpla Country Latt	ace (State or Foreign 7ia
	land show dat	ξ	10a. State 10b. Coun	ty		10c. City	y, Town or Lo	cation							100	d. Inside City Limits
	Mary 28a-f otifie	irec		tgom	ery			Silve	er S	Spring						1 🗆 Yes 2 ื No
	with the 23a or ist be r	Funeral Director	10e. Street and Number 3330 N. Leis	ure	World Bly	/d.,	#530	10f. Zip C	ode 0906	5		1		itizen of What (	Countr	y?
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1 Never Married 2XXMarried 1 Never Married 2XXMarried 1 Yes 2 X No If Yes, Give Year or Dates.    1 Never Married 2XXMarried   1 Yes 2 X No Specify:   Specify:   Specify:										14. Race - An Black, Wh Specify: Wh	ite, etc	o.		
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pu	filed valled  Be	17. Father's Name (First, Middle							18. Mother's Na	ame (Fin	st, Middle, M					
ryla	should be and Ment is marke	인	Marcis Bebr							Emma F						MD 20000
, Ma	1 and 2 sho f Health an item 27 is other trau	8	19a. Informant's Name/Relation Skaidrite Rit				19b. Mailin 333	g Address (Si	treet ar eis	nd Number or R sure Wor	iural Rou Cld	ite Number, 0 B <b>lvd.,</b>	City or #	r Town, State, 2 530, Si	Zip Cod 1ve	er Spring,
Baltimore,	∴Page 1 a tment of H tant; If ite jury or otl		0a. Method of Disposition  1													
Bal	permit. Departr Import any inji	2 2	21. Signature of Funeral Service Livensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spr. 23a Part 1 Enter the disease of complications that avoid the dark Port											ome Inc er Spri	ng,	MD 20901
~~	Physician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  As piration Pneumonia  a. Due to (or as a consequence of):												A	pproximate iterval Between onset and Death
400	Examiner	_	Sequentially list conditions,	臣	sophageal	Dys	functi	on								
	ed Signal	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury	< ∶	Due to (or as a	conseque	ence of):									
	execut an att	edical Examiner	that initiated events resulting in death) Last	C.	Due to (or as a	conseque	ence of):							_	-	
200	ate be ohysici the bu	dica		C d				-								
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician a completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Σ∣	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	23	c. If yes, outcome of 1  Live Birth 2  Pregnant at 9  Unknown	2 Fetal	death 3	Ectopic preg Other (specit	nancy fy)		-			23d. Date of de Month	elivery Da	ıy Year
s, P.O.	requires that the de been signed by the should be detached		Part II. Other significant condit Heart Failure	ions cont	ributing to death bu	t not resu ysfui	Iting in the un	derlying caus	e give ure	n in Part I. To Thr	ive			use contribute to		eause of death?
ord	w requ s been 2 shoul	Completed by			<u>.</u>							24a. Was an		24b. Were au	utopsv	findings available
Rec	The law cate has page 2:	E S										autopsy performe Yes 2	ed? No	prior to death? 1 \square Ye		letion of cause of
ital	sician: The la certificate harector, page	Be l	25. Was case referred to medica examiner?  1 ☐ Yes 2 🎛 No		spital:				6. Plac Other:	e of Death (Che		one)				
of V	g Physer this neral di	te: To	7. Manner of Death		28a. Date of injury	/ 2	R/Outpatient 28b. Time of	28c. I	Injury a	4 ☐ Nursing F		Resident		Other (Spec	cify)_	
ion	tendin leath. tor; Aft the fur	Certificate:	1 Natural 5 Pendi 2 Accident Invest 3 Suicide 6 Could	igation	(Month, Day,	Year)	injury		work? 1 □ Ye	es 2 🗆 No			,,			
Division of Vital Records,	il or At after of Direct d in by		4 Homicide determ		28e. Place of Injur building, etc.	y - At hom (Specify)	ne, farm, stree	t, factory, off	ice		28f. L	ocation (Streetly or Town, S	et and State)	d Number or Ru	ıral Ro	ute Number,
	Hospita 24 hours Funeral eted filled	Medical			an: To the best of n											s) and manner stated.
	To the within To the comple		only one) 3 ☐ Certifyin 9b. Signature and title of certifie	g Nurse i	Practioner: To the b	est of my k	knowledge, de	ath occurred at 29c. Lic	at the ti	me, date and pla	ace, and	due to the ca	ıu <b>se</b> (s	and manner as e signed (Monta	stated	1
	12		19 D	~	-, m -	is.			Ţ	D66249				Ly 14,		
		3	0. Name and address of person Jonathan Dura	who com					d, :	Silver	 Spri	ng, M	D 2	20910		
	State Registra		1. Date filed (Month, Day, Year)  JUL 16 201	0 /	32. Registrar											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 2010° Walter Braun 6:50 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Potomac Valley Nursing Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, May 16, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 AM 2 □ F Months Days Hours Min. 336-30-5273 74 May Illinois Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 AYes 2 No Montgomery Rockville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 603 Azalea Dr. #4 20850 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1962–64 1 ☐ Never Married 2 A Married 1 ☐ Yes 2 🗷 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NASA Research Scientist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Walter Braun Virginia Squire 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 <u>Cornelia Braun / Spouse</u> 15107 Interlachen Dr. #117, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐XCremation 3 ☐ Removal from State 7/19/2010 Brentwood, Maryland Ft. Lincoln Crematory 4 ☐ Donation 5 ☐ Other (Specify) MO1463 Simple Tribute 22. Name and Address of Facility 1040 Rockville Pike, Rockville, MD 20852 Approximate Interval Between Onset and Death ear ear Due to (or as a consequence of) Due to (or as a rionsaguante of) Due to (or as a consequence of) yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Show

Director

Funeral

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death v

within 72 hours after

s 1 and 2 should be filed with Health and Mental Hygier Item 27 is marked other them

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra

Baltimore, Maryland 21215-0036

Exami burial-1 attending physician Physician/Medical the as for use detached signed I ş Completed page 2 should certificate Be P

law requires that the death certificate be exect

P.O. Box 68760

Division of Vital Records,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certified funeral filled in by the

Certification: Medical completely

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart fallule. List only one cause on each line. Immediate Cav e (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Tyes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4

✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Registrar

29b. Sign

31. Date filed (Month, Day, Year) 16

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ture and title of certifier



DHMH 17 Rev 1/2001

VA

29c. License number

38262

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Am€	ended i	tei	State of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department /	tment of Health and ificate of Death WC		2010 23838			
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Herbert Cutter Carpenter	penter	2. Date of Death  Month  Da	2010 22:08			
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	40	c. County of Death			
,			PENINSULO REGIONAL MADICAL CENTU	If Under 1 Year If Under 24 Hrs.		Wicom i co			
	Funeral Director		213-38-0270 68 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 10/28/1941	9. Birthplace (State or Foreign Country) OH			
	nd <b>how</b> at	'n	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Local	tion		10d. Inside City Limits			
	laryla 3a-f s iffied	Director	MD Worcester Ocean Pi	nec		1 ☐ Yes 2🌠 No			
	or 28		10e. Street and Number	10f. Zip Code	10g. Ci	itizen of What Country?			
	with s 23a ust b	Funeral	82 Ocean Parkway	21811		USA			
	death item:			as Decedent of Hispanic Origin? (Sp/es, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.			
36	after (I", or xamir	d by	1 Never Married 2 X Married 1 Yes 2 X No	Yes 2 XNo Specify:		Specify: White			
8	within 72 hours after death with the Maryland giene. grenn "natural", or items 23s or 28a-f sho the Medical Examiner must be notified at the Medical Examiner.	Completed	Total of Battos.	nt's Usual Occupation	16b k	Kind of Business Industry			
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Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Manyland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden	Surname)			
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45	and 2 s Health tem 27 other tra		20a. Method of Disposition 20b. Place of Disposi	ean Parkway, Oce		ocation - City or Town, State			
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or otl once.	П	1 Burial 2 Cremation 3 Removal from State cemetery, crema	tory or other place)		ankford, DE			
alti.	permit. Pa Departmer Important any injury once.		oup mining	Name and Address of Facility Bu					
m	permit Depar Impo any ir	bi 1		08 William St.,	_				
	mysician/ Medical Examiner	er	Approximate Interval Between Onset and Death						
09/	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 burus after death.  within 24 burus after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):						
. Box 68760	he death certifi y the attending iched for use a			Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year			
ds, P.O	requires that the der been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		use contribute to the cause of death?			
Division of Vital Records, P.O.	The law recate has be page 2 sho	Completed			24a. Was an autopsy performed? 1 □ Yes 2 □ N	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No			
ţa	ician: certifi ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Che					
<u> </u>	Phys this ral dir	2	1 Ves 2 No 1 Nanner of Death 28a. Date of injury 28b. Time of	3 DOA 4 Nursing F	lome 5 Residence 28d. Describe how injur				
n	nding tth. : After	cate	1 Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation	work? M 1 ☐ Yes 2 ☐ No		,,			
27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide  2 Repending  1 Notatural  3 Suicide  4 Homicide  4 Homicide  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repending  2 Repen									
	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate ha completed filled in by the funeral director, page:	Medical	29a. Certifier (Check Check Officer) 1 Certifying Physician: To the best of my knowledge, death or (Check Officer) 3 Certifying Nurse Practioner to the best of my knowledge death or (Check Officer) 1 Certifying Nurse Practioner to the best of my knowledge of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the check of the ch	ation, in my opinion, death occurred	at the time, date and place	e, and due to the cause(s) and manner stated.			
	To th withii To th comp	-	29b. Signature and title of certifier	29c. License number		ate signed (Month, Day, Year)			
			I like land mn	034768		7 14 2010			
	5- M	12.5	30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	0	ed Salichi	IN MD 21801			
10	State	A		c (uin stra	-1 -0(11)//	11301			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Physici Medi Exami Funera Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ / Medica Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Virginia I. Carr  4a. Facility Name (inct institution, give street and number)  10461 Waterfowl Terrace  5. Social Security Number  6. Sax 218-09-2251  10 M 2X F  7. Age (in yrs. last birthday)  10a. State  10b. County  10c. City, Town or Location  MD  Howard  10c. City, Town or Location  MD  Howard  10c. City, Town or Location  Fill Under 1 Year   if Under 2 Hrs.   8. Date of Birth (Intrith, Day Year)   90 yrs.   Months   Days   Hours   Min.   (Intrith, Day Year)   91 year)   91 year)  10a. State  10b. County  10c. City, Town or Location  Fill Cott City  10c. Street and Number  3436 Rolling View Ct.  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?, 1 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo   11 yes 2 Lavo	ward  I. Birthplace (State or Foreign Country)  MD  10d. Inside City Limits  1  Yes 2 No  at Country?  d States  American Indian, White  ness Industry  Ome  e, Zip Code)  MD 21042  ty or Town, State  csville, MD  Family F.H. Ind									
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William O'Neale  19a. Informant's Name/Relationship (Type, Print) Nancy Provow - Daughter  20a. Method of Disposition 1 Burial 2   Gremation 3   Removal from State 4   Donation 5   Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Harry H. Witzke's  4   State of Disposition (Name of cemetery, crematory or other place) 22. Name and Address of Facility Harry H. Witzke's  4   Old Columbia Pike Ellicott C  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	MD 21042 tyorTown,State csville, MD Family F.H. Inc									
Nancy Provow - Daughter  20a. Method of Disposition 1 A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Harry H. Witzke's  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Crest Lawn  7-19-2010  Marriott  22. Name and Address of Facility Harry H. Witzke's  4112 Old Columbia Pike Ellicott C  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Shock, or heart failure. List only one cause on each line.  Due to (or as a consequence of):	MD 21042 tyorTown,State csville, MD Family F.H. Inc									
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the past 12 months?   23d. Date of the pas										
FFEMALE: 23b. Was decedent pregnant in the past 12 months?	n Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributions.	ite to the cause of death?									
1 ☐ Yes 2 ☑ No 3	☐ Probably 4 ☐ Unknown									
24a. Was an autopsy pric	re autopsy findings available or to completion of cause of									
performed? dea 1 Ves 2 No 1	tth? Yes 2 □ No									
25. Was case referred to medical examiner? 1	Acet Ing									
27. Manner of Death 28a. Date of injury 28b. Time of Owner (continuous) 27. Manner of Death 28b. Describe how injury occurred injury work? 28d. Describe how injury occurred injury work?	specilitas C. Livy.									
1 Natural 5   Pending   (Month, Day, Year)   Injury   work?										
28f. Location (Street and Number of City or Town, State)	r Rural Route Number,									
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of injury 28b. Time of injury M 1 Yes 2 No 28b. Injury at work? 1 Yes 2 No 28b. Injury at work? 1 Yes 2 No 28b. Injury at work? 1 Yes 2 No 28b. Describe how injury occurred injury occurred work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. Time of injury at work? 2 No 28b. T	us stated.									
	the cause(s) and manner stated. er as stated.									
29b. Signature and title of Certifier  29c. License number  29d. Date signed (N	Month, Day, Year)									
30. Name and address of person who completed cause of death (Item 23a) (Type, Brint)										
te 31. Date filed (Month, flag Year) 0 2010 32. Jegistrar's Signature	1 2010									
	1 2010									

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Sta

10-04921 Edward Russell Carson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 23840
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certi	ificate of	Death			Re _c	g. No.		
Physici		Decedent's Name (First, Middle,Last)				-		Date of Death Month	Day Yea	,	3. Time of Death
ledical Exam	iner	Edward Russell Carson  4a. Facility Name (if not institution, give street and number)		14	b. City, Town, o	r Location o		June 30, 20	4c. County of	of Death	1820 hrs
		Chester River Hospital Center		"	Chestertov		Death		Kent	Deali	
Funeral		5. Social Security Number 6. Sex 7. Age (	In yrs. las	t birthday)	If Under 1 Ye	ar If Unde	er 24Hrs.	8. Date of Birth	(MM/DD/YYYY		hplace (State or
Director		219-58-9220   1XM 2 F	59	Yrs.	Months Da	ys Hours	Min.	10/08	/1950	Foreign Cou	n untry) Maryland
		Usual Residence of Decedent				<u> </u>					
w any		10a. State 10b. County 10 Maryland Kent	c. City, T	own or Location		11 Po	nd				10d. Inside City Limits
Maryland 28a-f show any 1 at once,	jo						/IIG				1 Yes 2 X No
Mary r 28a- ed at	Director	10e. Street and Number 12775 Still Pond	Road	1	10f. Zip Code	216	67	10	g. Citizen of Wh	at Coun	try? USA
with the Maryland ms 23a or 28a-f sho be notified at once.	O E				Developed will			7 7	Lina		
ath w items	Funeral	1 Never Married 2 Married Armed Forces?			Decedent of H s, specify Cuba				White		can Indian, Black,
fter de  ", or  er.m		1 Yes 2 X	No	1	Yes 2 X N	o specify:			Specify:	Whi	ite
ours a atura	d by	15. Decedent's Education (Specify only highest grade complete	eted) 1		's Usual Occupa				16b. Kind of Bus	siness/Ir	ndustry
6 72 h an "n	mpleted	Elementary/Secondary (C-12) College (1-4 or 5+)			st of working life			"		_	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	шc	12		Real	Estate				Real		ate
15-1 filed al Hyg ed orb	Be Col	17. Father's Name (First, Middle, Last) George Russell Carson					s Name (F Elean (		aiden Surname)		
212 ould be Menta mark ic even	To B	19a. Informant's Name/Relationship (Type, Print )		19b. Mailing	Address (Stre				er, City or Town	ı, State,	Zip Code)
O ≒ 5 :5 :5	_	Jerome Feldman - Attorney		900 E	Bestgate	e Rd S	uite	200, A	nnapoli	s, N	1D 21401
ore, ME ss 1 and 2 s of Health au If item 27 her traum:		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State		ace of Disposit	tion (Name of ce	emetery,		Date	20c. Location -	City or 1	Town, State
Pages lent of int: I		4 Donation 5 Other Specify:			Cremato	ory	7/12	2/2010	Baltim	ore	, MD
Baltimore, permit. Pages l at Department of He Important: If ite		21. Signature of Funeral Service Licensee			ame and Addres		20111		ylor Fu		
		Miglin 1. Klobert	D								s, MD 21401
Physician		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	e death. D	o not enter the	e mode or dying	, such as ca	ardiac or re	espiratory arres	st, snock, or nea	л	Approximate Interval Between Onset and Death
Examiner	Multiple Injuries										Deaul
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	ner	if any, leading to immediate Due to (or as a consequence. Enter Underlying Cause	ence of):								
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ecuted and - transi		d									
8 5 -	Medical	UNPENDED AMENDED									
3760, ficate be g physicies the buriz		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome 1 Live birth	of pregna		al death 3	Ectonic	pregnancy	v	23d. Date of o	delivery Da	ay Year
Box 687  death certification at the attending and for use as the	sician/	past 12 months?	e of death	_ =	er (Specify)		programo.	,			.,
Bo le deat the at	Phys	1 Yes 2 No 9 Unknown 9 Unknown									
F.O. ires that th signed by be detach	by P	Part II. Other significant conditions contributing to death be	ut not resu	ulting in the un	derlying cause	given in Par	rt I.				he cause of death? ably 4 ✔ Unknown
quires en sign	ted							24a. Was ar			opsy findings available
Sorce law re has be 2 sho	Completed							autopsy	pr		empletion of cause of
tal Rection: The certificate ector, page	흥							1 <b>✓</b> Yes 2		<b>✓</b> Yes	2 No
of Vital Records, ng Physician: The law require ufter this certificate has been si neral director, page 2 should b	å	25. Was case referred to medical examiner?	2 🗸 FI	R/Outpatient		e of Death (			esidence 6	Other	
of V ing Phy After thi uneral d	၉	27. Manner of Death 28a. Date of Injury	2	8b. Time of Inj		ury at Work?	? 28	d. Describe ho	w injury occurre	d	
OD on sath.	흲	1 Natural 5 Pending Jun 30, 2010	1	643 hrs	1	Yes 2	No I	ubject drive hicle accid	r of vehicle i ent	nvolve	ed in motor
Division tal or Attendiu 13 after death. 14 Director: A	iji.	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury	/ - At hom	e, farm, street	, factory, office	building, etc			eet and Number	r or Rur	al Route Number, City
Di spital ours a filled	Certification:	4 Homicide determined (Specify) roady	vay				Ma	ain Street at 2	nd Avenue, B	etterto	n, MD
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending; completely filled in by the funeral director, page 2 should be detached for use as it		29a. Certifier (Check only one)  2  Medical Examiner: On the basis of examiner.									
To T To C	Medical	and manner stated.  29b. Signature and title of certifier			29c. Licens				29d. Date signe		
ED		Il 1 11 1 1 -		1	o.c.	M.E.	CCN	m	July 1, 2010		,
15		30. Name and address of person who completed cause of deat	h (Item 23	3a)							
		Theodore M. King, Jr., MD. Assistant Med	lical Ex	aminer 1	111 Penn St	reet, Ball	timore, I	MD 21201			
	ate	31. Date filed (Month, Day, Year) 32. Registrar's :	Signature	4 1							
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	-	For State Registrar		State of M	aryıan	•	artment of rtificate of	Health and N <i>Death</i>	-	Reg. No	001	n	2384	. 1
Physicia Medic			e (First, Middle, Last,	CL	1	2K			2. Date of De Month		y Zo`	Year O	3. Time of Dea	ath PM
Examin		4a. Facility Name (if	not institution, give s	treet and number)	TA	L	4b Gity, Town,	or Location of Death	E	4c.	. County of	f Death		
Funeral Director		5. Social Security No. 218-72-6	6336	7. Ag ☐ M 2 💢 F	e (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da APRIL 1	th y, Year) 1,19	957	g. Birthp Count MAR	lace (State or Fo ry) YLAND	reign
show dat	tor	Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	y, Town or Lo	ocation					11	0d. Inside City Li	imits
death with the Maryland ritems 23a or 28a-f sho ner must be notified at	Funeral Director	MD .  10e. Street and Num	HOWARD	COLUMBIA 10f. Zip Code					10- 0	nat Coun	1 XYes 2	□No		
with th	eral	9415	HICKORY	T.TMB				1045		rog. On	U.S		ily:	
items		11. Marital Status		12. Was Decedent Armed Forces?		3. 13.	Was Decedent of	Hispanic Origin? (Spo pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race -	tace - American Indian, Black, White, etc.		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by	1 🔀 Never Marri 3 □ Widowed		1 ☐ Yes 2 🛣 If Yes, Give Year or Dates.			1 ☐ Yes 2 <b>X</b> N				Specify:	BLA		
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yelar tofHe Hiter or oth		20a. Method of Disp 1 Burial 2	oosition Cremation 3 🗆 I	Removal from State	C	emetery, cre	osition (Name of matory or other pla	ace)	Date		ocation - C	•		
artmer artmer ortant injury			5 Other (Specify)		CH		S CREMATO		5-2010		VERDA			
Depar Impo any ir		1///	Man	nheuse	, , , , , , ,	91	CHAMBERS 5801 CLE	ess of Facility FUNERAL H /ELAND AVE	HOME & C	CREMA ERDAI	ATORI LE. M	UM,P D, 2	.A. 0737	
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To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medical E	IF FEMALE: 23b. Was decedent in the past 12,1 1 ☐ Yes 2 0 9 ☐ Unknown	pregnant 2 months?	3c. If yes, outcome 1  Live Birth 4  Pregnant a	of pregna	ncy	Ectopic pregna Other (specify)	ncy			23d. Date Mont		ry Day Year	
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iding Physici th. : After this cer • funeral direc	၉	examiner? 1  Yes 2 2  27. Manner of Death Natural 2  Accident	ZNNO	28a. Date of inju	ıry	ER/Outpatie 28b. Time o injury	f 28c. Inju		ome 5 Residence Residence Page 28d. Describe h					
27. Manner of Death  Very 1 to 1 to 1 to 1 to 2 to 2 to 2 to 2 to										Route Number,				
ne Hosp n 24 hou ne Funer pleted fill	Medical	(Check 2	Certifying Physi Medical Examin Certifying Nurse	er: On the basis of	examination	and/or inve	stigation, in my opir	ion, death occurred a	it the time, date a	and place	, and due to	o the cau	se(s) and manner	stated.
Z vith Som		29b. Signature and	D8/7 (	èsla,	140	)	29c. Licen	TZL3	4	29d. Da	te signed (i	Month, E	2010	)
		30 Name and addre	EPH (	Ampleted cause of c	ć	501	ST. P.	TUL PL	ALE	BA	-CTI	nin	E, MD	
Stat Registra		31. Date filed (Monti	h, Day Year) 16 2010	2. Registr	ar's Signat	far	ns.							

## Please Type or Print in Black Indelible Ink. Ensure

State of Maryland / Department of Health an Certificate of Death

e All Copies Are Legible.	
d Mental Hygiene 2 0 1 0	23842
2. Date of Death  Month  Day  Year  July 13, 2010	3. Time of Death 6:42 p M
	<del></del>

Physician /Medical Examiner

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

**Funeral** 

Director hin 72 hours after death with the Maryland ie. ian "natural", or items 23a or 28a-f show Nestical Examinar must be notified at

	Mary a-f sh	ķ	Rhode Island Newport		Jan	mestowr	ì	
	r 28g	by Funeral Director	10e. Street and Number				10f. Zi	рС
	3a o	<u>=</u>	169 America Way				02	83!
	ms 2	ner	11. Marital Status	12. Was Decedent Ever	r in U.S.	13. W	as Dece	eder
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03	urs a	ğ	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 19	95 <b>2–7</b>	'7   1	□Yes	240
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77	filed withir Hygiene. <b>other than</b> ent, the M	E O	Elementary/Secondary (0-12)	College (1-4or 5+) <b>4</b>			Waval	
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lan	d be ental ked o	To B	Bailey Connelly					
Mary	nd 2 shou lith and M 27 is mar r traumat	-	19a. Informant's Name/Relationship ( Cathleen Connelly/Da			19b. Mailing <b>4348 V</b>		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shany injury or other traumatic event, the Medical Examination must be notified once.		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cen	ce of Dispos netery, crem	atory or	othe
Balti	permit. Page Department of Important: If any injury or once.		21. Signatule of Funeral Service Licer			22. Fr	Name a	and /
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876	ate b hysic the bi	lica		_d				
39	ertific ling p	Mec	IF FEMALE:					
30	ath c	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal d	eath 3 🗌	Ectopic	
0	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at tim 9 ☐ Unknown	ne of dea	ıth 5□	Other (s	pec
Vital Records, P.O. Box 68760	ician: The law requires that the death certificate be encertificate has been signed by the attending physician rector, page 2 should be detached for use as the burial	Completed by Physician/Medical	Part II. Other significant conditions of	ontributing to death but no	ot resulti	na in the un	derlying	caus
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VIII.	ician sertifi ector	Be	25. Was case referred to medical examiner?	Hospital				
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Division of	or At	Certification:	4 ☐ Homicide determined	28e. Place of Injury - building, etc. (5	· At hom Specify)	e, farm, stre	et, factor	y, o
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	To the Hospital or Attending Phy, within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Medical	29a. Certifier  (Check only one)  1. Certifying Ph 2 Medical Exam	nysician: To the best of miner: On the basis of example and manner stated	aminatio	edge, death in and/or inv	estigatio	d at
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	2011		* Kachelle Ul	chen no				1
			30. Name and address of person who				rint)	_
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	Registr	ar	JUL 16 2010	peresno	13.	7		

Robert Bailey Con	nelly					July 13	, 20	ay 10	Year	6:42 p M
a. Facility Name (If not institution, giv Renaissance Gardens		Village		ty, Town, or	Location of Death		4	c. County	of Death	rge's
Social Security Number 6. S 131–22–6830	6ex 7. Age 1 □ XM 2 □ F 79	e (In yrs. last birth	day) If Un Month	der 1 Year ns Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Sept. 10	th ay, Year <b>1</b> 9	30	9. Birthp Coun C	lace (State or Foreigr try) alifornia
sual Residence of Decedent  Da. State 10b. County		10c. City, Town	or Location						11	0d. Inside City Limits
Rhode Island Newport		James								1 ∐ Yes 241∑No
De. Street and Number				Zip Code			10g. C	itizen of V	What Coun	try?
169 America Way			0	2835				USA		
I. Marital Status	12. Was Decedent E	er in U.S.	13. Was De	cedent of H	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No	)-		e - Americ	
1 ☐ Never Married 2 ► Married	Armed Forces? 1∑Yes 2 N If Yes, Give	lo		242 No	Specify:	nican, etc.)		Specify.	ck, White, e	itc.
3 Widowed 4 Divorced	Year or Dates:	1952–77							W	hite
15. Decedent's Ed (Specify only highest gra		1 (	Decedent's U Give kind of	work done (	during most of work	ing	16b. i	Kind of Bu	usiness/Ind	lustry
Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. DO NOT	l Offic			,,,	c w:	litary	
7. Father's Name (First, Middle, Last,			nava.	OLLIC	18. Mother's Nam	e (First, Middle				
Bailey Connelly				ŀ		Margaret			·	
9a. Informant's Name/Relationship (	Type. Print)	19b. I	Mailing Addr	ess (Street	and Number or Ru			<del></del>		
Cathleen Connelly/D			-		et, NW, Was				,,	,
Da. Method of Disposition		20b. Place of I	Disposition (/	Vame of	1	Date	20c. l	Location -	City or To	wn, State
1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Arlingto	crematory`c n Natio		Se _l	ot. 15	7\	linata	<b>~~</b> ₹77\	
Signatule of Funeral Service Licer		1	Franc	is J. C	ss of Facility	eral Home	Tnc		on, VA	
23a. Part 1. Enter the disease, or com	unlications that caused	the death. Do no			y Elvd. W.		•	ng, MD	20901	Approximate
shock, or heart failure. List only mmediate Cause (Final	one cause on each lin	e.	A CINCI TIO	lode of dyn	ig, odom do odmido	or respiratory a	11031,			Interval Between Onset and Death
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FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) 9 \( \text{Unknown} \)	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 🗆 Ectopi 5 🗆 Other	c pregnanc (specify)	у				te of delive onth	ery Day Year
art II. Other significant conditions of	contributing to death bu	ıt not resulting in t	he underlyin	n cause niv	en in Part I.	23e. Did t	obacco	use cont	ribute to th	ne cause of death?
Diabetes Mellitus, I	_	-				10		2 □ No		ably 41 Unknown
						24a. Was		24b. '	Were autor	psy findings available
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5. Was case referred to medical		-			26. Place of Deat			10	1 🗆 Yes	2 □ No
examiner? _1	Hospital: 1 ☐ Inpatie	nt 2 🗆 ER/Outr	atient 3 🗆	DOA Oth				6 □Oth	ner (Specif	v)
7. Manner of Death	28a. Date of Injui	ry 28b. Ti		28c. Injur Work		28d. Describe				·/
1 Natural 5 Pending 2 Accident investigation		, rear) III]	M		Yes 2□No					
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju- building, etc	iry - At home, farn :. (Specify)	n, street, fact	ory, office		28f. Location ( City or To	Street a wn, Sta	and Numb te)	er or Rura	l Route Number,
	nysician: To the best of miner: On the basis of and manner sta	examination and								
9b. Signature and title of certifier				29c. Licens	e number		29d. D	ate signe	d (Month,	Day, Year)
	eyeon Mo			DII	4156				12010	
). Name and address of person who		eath (Item 23a) (T	ype, Print)							
- 1 11 A /	exion, No	3110	Grace	felo	(Rd Si	Iver Spi	ring	3 M.	0 20	1904
Date filed (Month, Day, Year)	#32. Registra		-				-	,		

DHMH 17 Rev 1/2001

Registrar

JUL 1 9 2010

Maryland 21215-0036

Itimore,

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P.O. Box 68760

Division of Vital Records,

sproke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GEORGE KERMIT COYNE, TIIT 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY Social Security Numbe 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** ^{Year]} 1<u>936</u> 1 🖾 M 2 🗌 Months Days Hours Min. July 12 **Director** Massachusetts 018-28-5641 74 Usual Residence of Decedent show 10b. County 10a, State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Fairfax Alexandria Virginia 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22308 U.S.A. 1102 Alden Road within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🔼 No 3 Midowed 4 Divorced Specify: "natural" Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Maany injury or other traumatic event, the Mae College (1-4 or 5+) 5+ Elementary/Seconday (0-12) U.S. Navv Captain Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George K. Coyne, Sr. Eleanor Scully 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VA George Coyne, III - Son 1004 Danton Lane, Alexandria, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State Arlington National Cemetery Nov. 9, 2010 4 Donation 5 Other (Specify) Arlington, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Demaine Funeral Home VA 22314 520 S. Washington Street, Alexandria, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ ESOPHAGEAL CARCINOMA Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an certificate has autopsy prior to completion of cause of death? perform 1 Yes 2 No Yes 2X No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes 2 😾 No |2 1X Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural iniury 5 Pending s after death.

I Director: Af Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar

30

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COLLEEN DORRANCE CDR MC USN

DHMH 17 Rev 7/2009

9900650 (NC)

NATIONAL NAVAL MEDICAL

BETHESDA MD 20889-5600

CENTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ George Rhodes Cranford, Sr. 6:50 PM **Medical** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctor's Community Hospital Prince George's Lanham 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea January 27, 9. Birthplace (State or Foreign **Funeral** Months 1 X M 2 □ F Days Hours Min. 213-22-2456 82 Director Huntingtown, MD 1928 Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Prince George's Lanham 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7114 Riverdale Road 20706 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 

Yes 2 □ No Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced WWII Year or Dates. permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cranford Mechanical Plumber 8 Be timore, Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည John T. Cranford Virginia E. Rottan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice M. Cranford / Wife 7114 Riverdale Road, Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/15/2010 Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Soul Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ) ou ece Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events. Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy signed by the atte in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Tunknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes ours after death.

eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 Unpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner & Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Investigation Could not be 1 Yes Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State within 24 hours a

To the Funeral D

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b, Signature and title of certifier 6+ and a d cause of death (Item 23a) (Type, Print) 8118 Good huck Lanham

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JULY 2010 ANNE GLORIA DONNELLY 1:30A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY CARRIAGE HILL BETHESDA BETHESDA Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 □ M 2 🗹 Hours 1 1 / 28 / 1 9 2 1 Min. Yrs. **Director** <u>579-58-2523</u> 88 PA Usual Residence of Decedent 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD MONTGOMERY BETHESDA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20814 5215 WEST CEDAR LANE USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE and Mental Hygiene. 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hyglene. Important. If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SECRETARY GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ELLEN C. REYNOLDS RICHARD J. DONNELLY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shment of Health a lant. If item 27 is 19620 SELBY AVE., POOLESVILLE, MD 20837 RICHARD ROSE / NEPHEW 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 07/16/201 GATE OF HEAVEN SILVER SPRING, MD 4 Donation 5 Other (Specify) 21. Signature of Europeal Service License 22. Name and Address of Facility HILTON FUNERAL HOME BARNESVILLE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ CEREBRAL VASCULAR ACCIDENT disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated so or in Due to (or as a consequence of) sician and burial-transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Tes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 00 Other 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tle of certific 29c. License numbe 29d. Date signed (Month, Day, Year) JULY 12, 2010 D35579

Box 68760

P.O.

of Vital

Registrar DHMH 17 Rev 7/2009

State

SUSAN

J.

JUL

31. Date filed (Month, Day, Year)

MD 8218 WISCONSIN AVE., BETHESDA,

MD

20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Brakesia

MILLER,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Naomi Rachel Dixon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Allegany Western Maryland Regional Medical Center Cumberland Social Security Numbe 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country)
 Ohio 8. Date of Birth **Funeral** Months Days Min. December 20, 1917 92 Director 296-05-7147 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Examiner must be notified at Directo Allegany Frostburg 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 19522 National Highway, N.W. 10g. Citizen of What Country? items 23a Funeral 21532-U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. "natural", or à 1 Never Married 2 Married Yes 2 No 1 Tes 2 No Specify Specify: 3 Widowed 4 Divorced White Completed Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) homemaker homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ida Caroline Koons Arthur Clayton Hoover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Maryland 21532-19520 National Highway, N. Frostburg Jerry Dixon 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Frostburg Memorial Park 1 Surial 2 Cremation 3 Removal from State Frostburg Maryland July 15, 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. P. 1. Enter the disease, or complications that content the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 Unknown g Unknow death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 📈 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes <u>۾</u> Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

2

OH

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July 17 2010^{ear} 11:50 Brenda Gail Durnbaugh Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 4559 Sixes Road Prince Frederick Calvert Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 1 □ M 2 👽 F 02/20/1949 ar) Director 215-52-8745 61 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Calvert Broomes Island 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9010 Broomes Island Road 20615 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 Divorced Specify: White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Luther Elliott Annie Marie Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William F. Durnbaugh, Jr. / Husband P.O. Box 111, Broomes Island, Maryland 20615 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 St Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Southern Memorial Gardens : 07/21/2010 Dunkirk, Maryland . Signature of Funeral Service Licenses 22. Name and Address of Facility Kyle S. Simons MO1206 4405 Broomes Island Road, Port Republic, Maryland 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between OF LIVER Immediate Cause (Final Onset and Death 12RHOSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner mhis AUNDICE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has autopsy death? 1 Yes 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 No 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice House 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manne eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number To the Hospital within 24 hours a To the Funeral L Medical 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YRW FREDERICK, MD., 20678

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Registra

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland	/ Depa	artment of H	ealth ar D <i>eath</i>		gienen Reg. No.	0	23849
	Physici	an	1. Decedent's Name (First, Middle, Last)	, >				2. Date of De	ath Day	Year	3. Time of Death
	/Media		Konald Edwa					7-	12-3	2010	6:32pm
	Examir	er	4a. Facility Name (If not institution, give si			4b. City, Town, or			4c. Coun	nty of Death	Δ
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year	If Under 24		th	9 Birthr	place (State or Foreign
	Director			M 2□F 68	Yrs.	Months Days		Min. Aug. 28	1941	Caur	ington, DC
	pu ,		Usual Residence of Decedent								
	anyla ahov	'n	Maryland Prince Ge	eorge's Belts						1	10d. Inside City Limits
	the M	Director	10e. Street and Number	orge 5 Derc	PATT	10f. Zip Code	<del></del>		10 000		1 ☐ Yes 2 No
	with Sa or	Dir	11905 Gordon Avenue	<b>.</b>		20705			10g. Citizen o		Ť
	death ms 23	Funeral		2. Was Decedent Ever in U.S.	13.1		spanic Origin	? (Specify Yes or No		ed Sta	
9	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f ahow odical Examinational be notified at	Fur	1 Never Married 2 Married	Armed Forces? 12 Yes 2 □ No	_   '	f Yes, specify Cubar I□Yes 2 No	n, Mexican, F	Puerto Rican, etc.)	BI	lack, White,	etc.
203	ural',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates 1960–196	3	1 1 185 21 NO	Specify:		Spec	eify: Whi	Le .
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Maryland 21215-0036	2 should be and Mental Is marked o	To B	Hugh A. Day, III				Louis	e Poff			
lary	ges 1 and 2 should tof Health and Men If item 27 Is marke or other traumatic		19a. Informant's Name/Relationship (Typ					or Rural Route Numb			
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Ba	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Service Licenses	- A	Ď	Namaland Widres	Borgwa	rdt Funera	al Home	, PA	
			23a. Part1. Enter the disease, or complic	ations that caused the death.	Do not ente	+UU POWAEI  or the mode of dvina	r Mlll Lauch as ca	. KOAD Belt rdiac or respiratory a	tsv111e	, Mary	vland 20705 Approximate
4	Physician	1	Immediate Cause (Final	cause on each line.	- 11				•		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequen	RUI	Carcin	nome	α			un fromu
	Examiner	_	Sequentially list conditions, b.								
10	P A %	Iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer	ice of):						
	and and	Examiner	that initiated events resulting in death) Last	Due to (or as a consequer	ice of):						
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687		edlcal	d.								
Вох	attending p	In/M	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy		F			23d. D	ate of delive	ery
	deat	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deati 9 ☐ Unknown		Ectopic pregnancy Other (specify)			N	lonth	Day Year
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Records,	w requir been si should	Completed					-		Yes 2□No		
Rec	has law	mpl						— 24a. Was autop		. Were autor prior to cor death?	psy findings available impletion of cause of
		e Co	25. Was case referred to medical					1 ☑ Yes	2 No	1 ☐ Yes	2 No
	Physician: this certificated director, it	0 B	examiner?	spital: 1 ☑Inpatient 2 ☐ ER	/Outpatient			Death (Check only only only only only only only only		ther (Specif	
	g Ph ter thi	n: T	27. Manner of Death		b. Time of Injury	28c. Injury	at	28d. Describe			7
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≅	l or Att after de Direct J in by 1	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, office		28f. Location (5 City or Tox		iber or Rura	l Route Number,
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1	- 1		30. Name and address of person who com	pleted cause of death (Item 23	a) (Type, F	Print)			,		
			John S. Lah, m.D. 390	pleted cause of death (Item 23 of Ch Raven 32. Registrar's Signature	Boyl	evard Ba	Otimo.	re, mary	land 2	1218	2
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		Registrar  1. Decedent's Name (First, Middle, La	ast)		001	incate or	Death	2. Date of De	eath	-201	-U	3. Time of Death
Physicia Medic			Lucinda De	elgad	lo	·		July	13, ^D	^{ay} 2010	ear	3:48 ам
Examin	er	4a. Facility Name (if not institution, give		1	40	4b. City, Town, o	r Location of Dea			c. County of		
Funeral		Prince George's  5. Social Security Number 6.			ast birthday)	If Under 1 Year	Cheverl					lace (State or Foreign
Director		579-04-5679 1 M 2 V F 85 Yrs. Months Days Hours Min. April 26,1925 E										
s after death with the Maryland ral", or items 23a or 28a-f show Examiner must be notified at	tor	10a. State 10b. County		10c. City	y, Town or Lo	cation					10	0d. Inside City Limits
e Mar r 28a- notifii	Jire	Maryland Prince	George's			10f. Zip Code	ollege i	Park			$\perp$	1 X Yes 2 □ No
with th 23a o st be	Funeral Director		ouse Road,	#309		Tor. Zip Code	20740		10g. C	itizen of Wha	u.S	
eath v	Fune	11. Marital Status	12. Was Decedent E		S. 13. \	Vas Decedent of H	lispanic Origin? (	Specify Yes or No	-	14. Race -		
after d	by	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🗓 If Yes, Give	No		f Yes, specify Cuba  X Yes 2 □ No				Black, \ Specify:		
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1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship			19b. Mailir	ig Address (Street	and Number or F				e Zin C	ode)
nd 2 st salth a n 27 is er tra		Yolanda M. Vasqu	ez - Daugh	ter	1	Moon Ri			-			·
40 U V	- 69	20a. Method of Disposition 1   2 Burial 2 □ Cremation 3	☐ Removal from State	C	emetery, cren	sition (Name of natory or other pla	ce)	Date	l	ocation - Cit		
permit. Page Department o Important: If any injury or once.		4 Donation 5 Other (Spec	cify)	Gat	e 0 f H	eaven Ce	m. 07/	20/2010	Si	lver S	pri	ng, MD
Depa Impo any i		21. Signature of Funeral Service Lice	hsee	294								Home, Inc. g. MD 2090
		23a. Part. Enter the disease, or cor	mplications that caused	the death					_			Approximate
Physician/		shock, or heart failure. List only Immediate Cause (Final disease or condition			diac A	rrhythmi	a					Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or as a	consequ	ence of):	. o drag drame						
	ē	Sequentially list conditions,	b. Hyper									
uted d ansit	Examiner	If all, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events  Congestive Heart Failure										
exectian an	al Ex	resulting in death) Last	Due to (or as a									
ath certificate be executed attending physician and for use as the burial-transit	ğ	•	<b>d</b>								+	
pertific nding	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of							23d. Date o	f dolive	n/
death e atter	sicia	in the past 12 months? 1  Yes 2  No	1 ☐ Live Birth : 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnand Other (specify)	су			Month		Day Year
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Physic this c	유	1 Yes 2 X No 27. Manner of Death	Hospital: 1 1 Inpatie		ER/Outpatien 28b. Time of	t 3 DOA Oth	4 ☐ Nursing	Home 5 Resi			pecify)	
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pital o		[77]						1				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 Medical Exan	ysician: To the best of r niner: On the basis of ex irse Practioner: To the b	amination	and/or invest	gation, in my opinio	on, death occurred	at the time, date a	and place	, and due to	the caus	se(s) and manner stated
To the within To the comp	≥	29b. Signature and title of certifier	TSE FTACUONET. TO THE	Jest of Hig	Kilowieuge, u	29c. License		lace, and due to tr		te signed (M		
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		30. Name and address of person who					4- 010	0:0	0	1	^	
State	,	31. Date filed (Month, Day, Year)	32. Registra		IRS VA	ive, Sui	te 210,	silver!	spri	ng, Mo	vryl	and 20902
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2010 1 - State Registra AMEND#23 openMD, 7/20/10, EMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Arbutus E. Duckett 10 July 6:07 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Manor Care of Silver Spring Silver Spring Montgomery . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month Day, 1 M 2 DXF Months Days Hours Min 215-18-0246 92 Maryland Director Usual Residence of Decedent 28a-f show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗆 No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20901 11200 Lockwood Dr. #1604 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No If Yes, Give Year or Dates 1 Yes 2 X No Specify: **Black** Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be Department of Health and Mental Hy Important: If item 27 is marked othions any injury or other frames. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Herbert S. Duckett, Sr. Laura Ellen Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11200 Lockwood Dr. #1604 Silver Spring, Md 20901 Florence B. Mitchell/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) St. John AME Zion July 17,2010 Odenton, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave. NW Washington, DC 23a. Lort 1. Enter the disease, or complications that cau, of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate 10 nse lahan Death Arrythmia Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Arox.15 Mi Myocardial Infarction Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of that the death certificate be executed years Hypertension resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) Yes 2 No ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Failure to thrive To the Hospital or Attending Physician; The law requires 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Dementia 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical B 26. Place of Death (Check only one) Hospital: 2 🔀 No Other: 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of cer 29d. Date signed (*Month, Day, Year*)
7 · 1 5 · 20 / 0 29c. License number 960

Registrar
DHMH 17 Rev 7/2009

State

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

back

10810 Darnestown Road, #202, Gaithersburg, Maryland 20878

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

oth, Day, Year)

31. Date filed (Ma

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 1 0

1 - For State	Amend Item strar	25 per me, g	906,08/	lepartment of F 06/2010dhb Certificate of L	Health and N Death	lental Hyو/ ا	giene2010 Reg. No.	23852		
	ent's Name (First, Middle	,				2. Date of Dea Month	ath Day Year	3. Time of Death		
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V L.⊑ . □	l Status ever Married 2 ☐ Marr /idowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1  Yes 2  If Yes, Give Year or Dates.		13. Was Decedent of H If Yes, specify Cuba  1 ☐ Yes 2 🏋 No	ın, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:			
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Baltimore,  oemmit. Page 1 and Department of Hea Important: If item any injury or other any injury or other 71. Signa		3 ☐ Removal from State	cemetery,	Disposition (Name of crematory or other place erans Cemet	e)	/10	20c. Location - City or Crownsvill			
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To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,  Medical Certificate: To Be (    C   C   C     C   C     C   C     C   C	ck 2 🖳 Medical Ex	Physician: To the best of n aminer: On the basis of exa Nurse Practioner: To the b	amination and/or ir	nvestigation, in my opinio	n, death occurred at	the time, date and	d place, and due to the d	ause(s) and manner stated.		
29b. Signa	ture and till of certifier	Vornte	- mo	29c. License	number 03844	3	9d. Date signed (Month	, gay, Year) 2010		
	1 16. VV	ho completed cause of dea	ath (Item 23a) (Typ	pe, Print Rid (-)	1 Ave	Ar	mapely	m		
State 31. Date fil Registrar	ed (Month JUL Year) 4	2010 32. Jegistrar	's Signature	pare		/				

	A	Pleas mend 10a-c & 10e-	se Type or Prings f, per INF State of Ma	nt in Blac G910 12 aryland 71	k Ind /7/1 Depar	delible Ink 0 TT tment of H	<b>c. Ens</b> i lealth a	ure A and M	II Copie: Iental Hy	s Are Le	egible	<b>.</b>	
		For State Registrar				ificate of E				Reg. No. 2	nin	) 23	253
Physic	ian/	1. Decedent's Name (First, Middle,	Last)						2. Date of Dea		Year		of Death
Med	lical		Delmaige						July	Day 4	201		<u> </u>
Exam	iner	4a. Facility Name (if not institution, g Suburban Hospit	,			4b. City, Town, or Betheso		of Death			nty of Dea		
Funera			i. Sex 7. Age	(In yrs. last birth		If Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of Bird	th	9. Bi	rthplace (State	or Foreign
Directo	r	124-32-3040 Usual Residence of Decedent	1 □ M 2 🖾 F 8	5	Yrs.	VIOITIIS Days	Hours	IVIII1.	(Month, Da April 2	7,1925	Ho	ountry) nduras	
and show	٥	10a. State 10b. County		10c. City, Town	or Loca	tion						10d. Inside	City Limits
Maryla 28a-f	iect	New York   Montgo		Kensin	gton	r Brook	lyn			_		1 🔀 Y	es 2 🗆 No
th the	Funeral Director	10e. Street and Number 1250 I 3616 Littledale	lancock Stre	et		10f. Zip Code	11221			10g. Citizen		-	
ath wii ems 2: must	uner	11. Marital Status	12. Was Decedent E	ver in II S	13 Wa		spanic Orio	nin? (Spe	cify Yes or No-			erican Indian,	
or ite	by F	1 Never Married 2 Marrie	Armed Forces? d 1 ☐ Yes 2 🔀 1		1	as Decedent of His es, specify Cubar					Black, Whi	te, etc.	
Unraff		3 Widowed 4 XDivorced	If Yes, Give Year or Dates.		¹ x	Yes 2 □ No	Specify:	Hon	duran	Spec	cify: B.	Lack 	
15-0 72 ho n "nat fedica	Completed	15. Decedent (Specify only highest	grade completed)		(Give kin	nt's Usual Occupa nd of work done d NOT use retired)		of worki	ng	16b. Kind o	f Business	s Industry	
VITA within giene.		Elementary/Seconday (0-12)	College (1-4 or 5-	l-1		ied Nurs	sing A	Assis	stant	Healt	h Cai	re	
ire, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "ratural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, La Esteban Lope	*						e (First, Middle, na Lope		ame)		
ould bould bud Mer		19a. Informant's Name/Relationship		19h	Mailing	Address (Street a			*		n State 7	in Code)	
, Ma d 2 sh salth ar n 27 is er trau		19a. Informant's Name/Relationship (Type, Print)  Keith Reid - Son  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z											.0
		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3	B ☐ Removal from State		y, cremat	tory or other place			Date			r Town, State	
Baltimo permit. Page Department ( Important: If any injury or		4 Donation 5 Other (Sp	AHA	George	Was	hington Name and Addres	Cemi.		1/2010				20
Balti permit. Departr Imports any inji		21. Signature of Funeral Service Lic	13 Myb	m		00 Georgi							
		23a. Part 1. Enter the disease, of c shock, or heart failure. List on	omplications that caused y one cause on sagn line.	the death. Do n	ot enter t	the mode of dying	g, such as o	_				Approxim Interval B	
hysician	_	Immediate Cause (Final disease or condition	- Au	ute	M	to card	dial	بك	where	chon	,	Onset and	
Medica Examine	•	resulting in death)		consequence o	f): (a	Joseph	d	rsco	rsel				
As to	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence o		74	(Pe	TT					
execution and ial-tran	Exal	Cause (Disease or iinjury that initiated events resulting in death) Last	` ,	consequence o	f):	$\gamma$	1	ail					
oc ate be o	dica		La. Ch	Somic	K	enal		011	UNC				
ertifica ding p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy			V	/		224	Date of d	olivon	
<b>BOX 68 / 60</b> death certificate b he attending physi ed for use as the k	Physician/Medica	in the past 12 months? 1 \( \sum \) Yes \( 2 \sum \)XNo	1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnancy Other (specify)	у		-		Month	Day	Year
that the ned by the detacher	Phy	9 Unknown  Part II. Other significant condition		ıt not resultina ir	the und	derlying cause give	en in Part I		23e Did to	obacco use c	ontribute t	o the cause of	death?
signe d be d	d by					, , , , , , , ,				Yes 21 N		Probably 4	
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r VIII  Physic  this ce al dire	ြု	Yes 2 ☐ No 27. Manner of Death		nt 2 ER/Out			4 ⊔ Nu		me 5 Resid			cify)	
on or nding Ph tth. : After th e funeral	cate	1-Natural 5 Pending 2 Accident Investiga		y 28b. Ti Year) in	ime of ijury	28c. Injury work? M 1 -1	rat ? Yes 2□		28d. Describe h	now injury occ	urred		
<b>DIVISION</b> tal or Attendir rs after death. al Director: Af ed in by the fu	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ot be	y - At home, far (Specify)	m, street	t, factory, office			28f. Location (S City or Tow		mber or R	ural Route Nur	nber,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit			hysician: To the best of n										
the Ho hin 24 I the Fu npleted	Medical	only one) 3  certifying N	aminer: On the basis of ex lurse Practioner: To the b			ath occurred at the	time, date			e cause(s) and	manner a	s stated.	nanner stated.
2 1 2 Cor Siting		29b. Signature and title of certifier	neddy			29c. License	1369	1		29d. Date sig	ned (Mon	). Vo	10.
		30. Name and address of person when		ath (Item 23a) (T	ype, Prin	DE DE	N	Jud	Ray	de a 11 a	0	Mes	
		31. Date filed (Month), Day, Year)	32. Registrar	Swo ]	D.W	W COUL	/>	100	, 1-0	JWI ITE		*/,	
St Regist	ate	111 1 R	2010 Sz. Aegiswar	Olyriatur	Mar	Red							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0137 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 504 Sweet Gum Road Riva Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 🗆 F 214-46-2070 Months Davs Hours Min. (Month, Day Year) 61 **Director** Washington DC Usual Residence of Decedent y filed within 72 hours are tall Hygiene.
Led other than "natural", or items 23a or 28a-f show cevent, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Riva 1 Yes 2 X No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 504 Sweet Gum Road 21140 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 K No Specify: Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Electrician Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F is marked o permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Robert Y. Flynn Alma Loane 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Robert D. Flynn - Son 1744 Havre de Grace Dr, Edgewater, MD 21037 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 🛣 Cremation 3 🗆 Removal from State Baltimore Crematory 7/19/2010 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed physician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician by Physician/Medical use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 Unknown been signed by the s should be detached t 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed' certificate 1 Yes 2 No Yes 2 No I or Attending Physician: after death. To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

Name and address of person who co

10 HAEZ 31. Date filed (Month, Day, Year)

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 9:00 A Jane Marie Ford Ju1v Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2955 Eastern Neck Rd. Rock Hall Kent Social Security Number 6. Sex Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 **X** F (Month, Day, Year) 6/18/19 Director 220-42-2655 Usual Residence of Decedent show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland It item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🏝 No MD Rock Hall Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2955 Eastern Neck Rd. 21661 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Completed by Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: d Mental Hygiene. marked other than "natural", 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Medical Technician Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Norbert Charles Nitsch, Sr. Ethel Katzenberger permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Ford/ Son Beech Rd. Wallingford, PA 817 19086 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) John's Cemetery 7/7/2010 Rock Hall, MD 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home Signature of Funeral Service License 30 Speer Rd. Chestertown. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant
9 Unknown Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) 24a, Was an After this certificate has autopsy performed Yes 2 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Hospital Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending ☐ Accident
☐ Suicide Investigation after death Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) e Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 3 □ 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) mo 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Susm 516 31. Date filed (Month, Day, Year) 32. Registra

Registrar DHMH 17 Rev 7/2009

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	Funeral Director	Г	5. Social Security N 5 7 7 - 50 - 557 50 - 93	1314	6. Sex 1 ☐ M <b>2^N</b> F	7. Age	e (In yrs. last birt	hday) Yrs.	If Under 1 Months	<u>Year</u> Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	irth ay, Year	9. Birthplace (State or Foreign		
	and show Lat	'n	Usual Residence of 10a. State	Decedent 10b. County			10c. City, Towr	n or Lo	cation								10d. Inside City Limits
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	within 72 hours after death with the Maryland glene. glene. er than "natural", or items 23a or 28a-f show, the Medical Examiner must be notified at	Funeral Director	10e. Street and Nur 5559 Phelp		r.	10f, Zip Code <b>2104</b> 5						_	Citizen of \ <b>USA</b>	of What Country?			
	r death or items siner m		11. Marital Status 1 ☐ Never Marr	ind 2 Nam	12. Was Dece Armed For	edent E	ver in U.S.	13. \	Vas Deceder f Yes, specify	t of His	spanic Or n, Mexica	igin? (Spen, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - American Indian, Black, White, etc.		
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/lanc	uld be filed w Mental Hyg narked othe natic event,	10	17. Father's Name (I		•						18. Moth		e (First, Middle Cia Mary			*)	
Baltimore, Maryland	e 1 and 2 should be file of Health and Mental I f item 27 is marked o r other traumatic eve	ī	19a. Informant's Na Michael W	. Fato/S			19b	. Mailin <b>'70</b> 9	ng Address (S <b>Twin O</b> e	treet a	nd Numb Way, I	er or Rura aurel	NOTE NUMBER 1	mber, City or Town, State, Zip Code)			
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				t failure. List o	complications that only one cause on ea	caused ich line.	the death. Do n										Approximate Interval Between
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	Examiner	er	Hypertension									1/	/				
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_	exec an a ial-tr	al Ex	resulting in death) L		Due to	or as a	consequence o	f):			ERTIFICA	ION APPRI	2450				
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Box 68760	to <b>one Populate of Attending Physician:</b> The law requires that the death certificate be exwirtin 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial		23b. Was decedent in the past 12 n 1 Yes 2 9 Unknown	ngaths?		Birth 2 nant at	f pregnancy E Fetal death time of death					23d. Date Mon		e of delivery nth Day Year			
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Division of Vital Records, P.O.	ortal or A ours after aral Directilled in by	al Cer	286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  286. Location (Street and Number or Rural Route Injury - State)														
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			29b. Signature and ti	tle of certifier	Court		M.D	)			number	515	_	29d. Da	ate signed	(Month, 1	* *
	4		30. Name and addre		ho completed caus	e of dea	ath (Item 23a) (T	ype, Pr	int)		Cal	1/14	1	4.3			•
a)	State Registra	٠ ا	31. Date filed (Month		/32. Re		s Signature	and	1	~ -		V 1/4	019 6	w o	210		

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Completed by Funeral

Be

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MD

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Ilmportant: If item 27 is marked other than "matural", or items 23a or 28a-f show any lnjury or other traumatic event, in Northan Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event in the Maryland Show Ancel Event In the Maryland Show Ancel Event In the Maryland Show Ancel Event In the Maryland Show Ancel Event In

Baltimore, Maryland 21215-0036

physician and s the burial-tran attending p for use as t detached been signershould be of certificate has birector, page 2 sl funeral To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu

Hospital or Attending Physician: The law requires that the death certificate be executed

this

Division of Vital Records, P.O. Box 68760,

Alloale	CFS P	22. Name and Address of Facility F	Framptom Fun Federalsbur	eral Home, P.A. eg, MD 21632
23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line,	not enter the mode of dying, such as card  TIC MELAWOI  of):		Approximate Interval Between Onset and Death VEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1  Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	contributing to death but not resulting i	n the underlying cause given in Part I.		2 No 3 Probably 4 Onknow  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
25. Was case referred to medical examiner?		26. Place of D	eath (Check only one)	TETES ZEINO
1 ☐ Yes 2 A No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	0.0	Home 5 ☐ Residence	6 □Other (Specify)
27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Time of njury at Work?  M 1 □ Yes 2 □ No	28d. Describe how inj	
3 Suicide 6 Could not be determined		rm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
29a. Certifier (Check only one)  1 Certifying Pr 2 Medical Exar	nysician: To the best of my knowledge niner: On the basis of examination ar and manner stated.	e, death occurred at the time, date and pla id/or investigation, in my opinion, death oc	ce, and due to the cause curred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and title of certifier	lhh ATTENDING	29c. License number 005 3 0	994 = 29d. D	Date signed (Month, Day, Year)
30. Name and address of person who PAUL M·Re 31. Date filed (Month Day Year)	completed cause of death (Item 23a)	1 BLOOMINGDALE	FEDE	RALSBURG, MD

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0134 301 2010 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner IMURE INIVERSITY OF MARYLAND MEDICALCENTED If Under 1 Year | If Under 24 Hrs. Date of Birth (Month Day, year) 4/25/1928 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 82 165-22-7000 PA Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 23a or 28a-f show ust be notified at 1 ☐ Yes 2 No Director MD Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number the Medical Examiner must be 2806 Pinewick Road United States 21042 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊉Yes 2 □ No If Yes, Give Year or Dates: items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No Specify. by Specify. White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Facilities Engineer NSA s 1 and 2 should be filed wi f Health and Mental Hygien item 27 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugene Geibig ပ Miriam Stein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If item 27 Is any Injury or other trains 2806 Pinewick Rd. Peggy Geibig - Wife Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State Crest Lawn Mem. Gdns. 7/19/10 Marriottsville, MD 4 ☐ Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signatur Fune | Service Lensee M01411 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) EMBOLISM **Physician** ULMONARY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autonsy perforr certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2 ER/Outpatient 3 DOA 2 1 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: the Hospital or Attending 1.XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

P.0. Division or Vital Records,

51

State Registrar

CORWIN

29b. Signature and title of certifier

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMURE MD Z120 GREE SOUTH

			1 - For State Registrar	State of Ma	arylan	•		nt of H				Reg. No.	2011	2:	385
	Physic /Medi		1. Decedent's Name (First, Middle, Li Sylvia	Ann			Gray	У			2. Date of De Month July	Day	Year 2010	3. Time o	М
	Examir Funeral			1th Care Co	e (In yrs. I	ast birthday)		Cumb er 1 Year	Location o erlan If Under 2 Hours	d	8. Date of Bir (Month, Da 06/02/		Allega	ny pplace (State	or Foreign
	Director show		Usual Residence of Decedent  10a. State 10b. County		9 10c. City	Yrs. y, Town or Lo		Days	Tiodis	IVIII I.	06/02/	1941	Mar	untry) yland 10d. Inside (	City Limits
	with the Mar a or 28a-f sl	Funeral Director	MD Alle  10e. Street and Number  453 Baltimore	Avenue		Cum	berl 10f. Z	and  ip Code 215	02			10g. Citiz	zen of What Cor USA	untry?	s 2∏No
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "hatural", or items 23a or 28a-f show amportant: If item 27 is marked other traumatic event; Ite Madical Exercites must be notified at once.	b	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Milloworced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		16a. Dece	1 ∐Yes dent's Us	edent of Hi ecify Cuba 2 No	spanic Orion, Mexican  Specify:		cify Yes or No lican, etc.)		14. Race - Amer Black, White Specify:	ican Indian, , etc. hite	
	2 should be filed within 7 and Mental Hygiene. Is marked other than "r aumatic event, the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median and the Median	Be Completed	(Specify only highest g. Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Las	College (1-4or 5	College (1-4or 5+)			ekeep						ial Managemen	
Maryland	12 should be f h and Mental 7 Is marked or rraumatic eve	10 E	Wilbur E.  19a. Informant's Name/Relationship Roy L. Gray /Son		Thr		•	•	and Numbe				r Town, State, 2	Auvil (ip Code) 502	
Baltimore, I	permit. Pages 1 and 2 Department of Health Important: If item 27 I any Injury or other tra once.		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Spec	☐ Removal from State	I -	lace of Dispo emetery, crer on Mem	sition (Natory or	ame of other place	9)	Da	/2010	20c. Lo	cation - City or l	own, State	
Balt	permit. Departn Importa any Inju		21. Signature of Funeral Service Lice	dans			404	Decat	ur St	reet	, Cumb	erlar	Tuneral nd, MD	Home, 21502	
, de	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or cor shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. Due to (or as	stat a consequ	uence of):	) Ve	1		me .		arrest,		Interval Be Onset and	etween .
Box 68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	ical	IF FEMALE: 23b. Was decedent pregnant	Due to (or as d									23d. Date of deli	verv	
P.O. Bo	at the death by the atter tached for L	Physician/Med	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🗌 Fetal	death 3	Ectopic Other (	pregnancy specify)					Month	Day	Year
Records, F	w requires that been signed should be det	2	Part II. Other significant conditions	contributing to death b	ut not resu	ulting in the u	nderlying	cause give	en in Part I.		23e. Did 1	3	se contribute to	the cause of obably 4	
al Rec	fan: The law re rtificate has be ctor, page 2 sho	Completed								24a. Was auto perfo 1 □ Yes		24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No			
Vital	yslcłan; is certific director,	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ◯ No	Hospital:	nt 2 🗆 I	ER/Outpatier	ot 3□ [	Othe	r.		(Check only		6 ☐ Other (Spec	26.0	
	ding Phys h. After this funeral di	n: To	27. Manner of Death	28a. Date of Inju	ry	28b. Time of injury		28c. Injury Work		_	8d. Describe			<i>шу)</i>	
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	1/2 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not 4 Homicide	M eet, facto	M 1 □Yes 2 □No			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	the Hospit in 24 hour the Funera	Medical (	(Check only 2 Medical exa	Physician: To the best iminer: On the basis of and manner sta	examinat		vestigation	on, in my o	pinion, dea			, date and	place, and due	to the ceuse	(s)
D	2 m	2	29b. Signature and title of certiffer	John				9c. License D33					e signed (Monti		
	nes		30. Name and address of person who Sunil K. Gupt		eath (Item 625 K	(Type, Cent A	Print) venu	e, Cu	mberl	and,	MD 2	1502			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Register	ar's Signat	ture									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar 23860 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0027A M William 2010 Lee Hall Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death NICOMICO SALISBUL g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 1 M 2 □ F (Month, Day, Year) Feb. 5, 1947 Days Virginia **Director** 229-66-6542 63 Usual Residence of Decedent 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No **Accomack** New Church VA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 30401 Cutler's Court Road 23415 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, py 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. Vietnam 1 Yes 2 X No Specify: white "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Utilities Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပု Virginia Mae Johnson William Ben Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 445, Tasley, VA 23441 Mary Ruth Hart (sister) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State 7/19/2010 Oak Hall, VA Downings Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungal Service Licensee Holloway Puneral Home, Professional Association 107 Vine Street, Pocomoke City, MD 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final methicillin resistant Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner endocard Sequentially list conditions sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9.T KH Charles MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

/illiam John Hai		State 1- For State Registrar	of Maryland /		nent of cate of		and	Mental		Reg. N	. 20	10	23	386
Physicia ledical Examir		Decedent's Name (First, Middle,Las     William John	•						2. Date of De Month	eath Day		3	1235 h	
edicai Examii	ier	4a. Facility Name (if not institution, giv			4	b. City, Tov	vn, or Lo	cation of De	July 9, 2		4c. County of	Death	12331	
		Frederick Memorial Hospit	tal			Frederi	ck				Frederick			
Funeral Director		5. Social Security Number 212-33-4380 6. Se		(In yrs. last bi	irthday) Yrs.	If Under Months	1 Year Days	If Under 24	Hrs. 8. Date of I	Birth ( <b>M</b> ) 15,	M/DD/YYYY) 2010	9. Birth; Foreign Coun		Land
ye.		Usual Residence of Decedent  10a. State 10b. County	11	0c. City, Tow	n or Locatio	nn.					•	Ιı	Od Inside	City Limits
how ar		Maryland Frederi	ick		ersvi									2 X No
he Marylan 1 or 28a-f s ified at on	Director	10e. Street and Number 2020 Canada Hill	L Road			10f. Zip Co 217				10g. C	itizen of Wha	t Countr	y?	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1xx Never Married 2 Married	12. Was Decedent E Armed Forces?	ver in U.S.					(Specify Yes or Nerto Rican, etc.)	10-	14. Race - White,	etc.		Black,
s after ral", o	by F		If Yes, Give Year				No s				Specify:		hite	
36 in 72 hour: han "natu lical Exan	Completed	15. Decedent's Education (Specify or Elementary/Secondary (0-12)	Ny highest grade comp College (1-4 or 5+	-)	during mo	st of working	ng life. D	i (Give kind i O NOT use i	of work done retired)		. Kind of Busi			
d with	ĕ	10 17. Father's Name (First, Middle, Last)		G.	lass :	IIISta.		Mother's Na	me (First, Middle		mmercia n Surname)	aı D	ulla	ıng
21215-0036 buld be filed within 7   Mental Hygiene.   marked other than   event, the Medica	Be	William A. Hanli							tte Oake					
D 21 should and Me	မ	19a. Informant's Name/Relationship (T							or Rural Route N					
and 2 sho lealth and tem 27 is traumati	ı	Annette Cooney -  20a. Method of Disposition	- mother	20b. Place	020 Ca of Disposit	anada tion (Name	Hil of cemet	l Road	d, Myers	vil 20c	Le, Ma:	ryla ity or To	nd 2 wn, State	21773
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		1 Burial 2XX Cremation 3	Removal from State	crema	atory or other Efer (	er place)			17-2010	F.	rederio	o k	Mary	land
altin nit. Pa artmer sortan ury or		4 Donation 5 Other Specify: 21. Signature of Funeral Service Green	see /	// Scau					Stauffer					Land
in Top Be		Sharon (ey	melle C	line					Pike, F					1 21
Physician Macical		23a. Part I. Enter the disease, or comp failure. List only one cause on ea		ne death. Do r	not enter the	e mode of c	lying, su	ch as cardia	c or respiratory a	rrest, sl	hock, or heart		Between	ate Interval Onset and
Examiner	- 1	1141 111 1 1 1 1	Asphyxia Due to (or as a conseq	uence of):								-	De	eath ————
			Hanging	derice or).										
	ije	if any, leading to immediate	Due to (or as a conseq	uence of):										
uted nd ransit	Examiner	(Disease of Injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):										
50, te be executed ysician and burial - transit	edical	UNPENDED	AMENDED								_			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	ΣΙ	IF FEMALE: (3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome  1 Live birth  Pregnant at tir  Unknown	no of dooth	2 Feta	al death er (Specify		Ectopic preg	gnancy	2:	3d. Date of de Month	elivery Day	,	Year
that the d	by Ph	Part II. Other significant conditions	contributing to death b	out not resulti	ng in the un	iderlying ca	use give	n in Part I.		_	v use contribu	_		
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n of Vi ding Physi 1. After this funeral dir	읩	1 ✓ Yes 2 No 27. Manner of Death	28a Date of Injury	2 🗸 ER/0	. Time of Inj		. Injury a		sing Home 5 28d. Describe		lence 6 j			
on on cath.	힐	1 Natural 5 Pending	FOUND: Day, Yea		UND: 55 hrs	1	Yes	2 🗸 No	Subject ha	nged	self			
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Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier 1 Certifying Physicia	an: To the best of my keen: On the basis of examinand manner stated.										:ause(s)	
E 2 E 8	Me	29b. Signature and title of certifier	// Stated		<del></del>	29c, L	icense n	umber		29d.	. Date signed	(Month	, Day, Year	r)
7		Afker brass	dul	)		C	D.C.M.I	E.		Jul	ly 10, 2010	)		
		30. Name and address of person who of Melissa Brassell, MD As	ompleted cause of dea			nn Stree	ot Ralf	timore, M	D 21201					
Sta	ale a	31. Date filed (Mon Pay, Year).	32. Registrar's				, Dall		D 2 1201	-				
Registr	_	JUL X 0 20	LA LANGERAS	a pr.	par	Jan San San San San San San San San San S								

Certificate of Death

1. Decedent's Name (First, Middle, Last) 1 Day **Physician** JULY RAYMOND JOSEPH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **ENVOY CENTER** DENTON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2 □ F 142-12-5146 DEC 13, 1923 86 Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at MARYLAND CAROLINE DENTON Director Pages 1 and 2 should be filed within 72 hours after death with the I nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or items 23a or 28a-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 must be n 908 GAY STREET, APT C 21629 Funeral ural", or items 2 I Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1942-46 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X TXNo 2 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) U.S. GOVERNMENT College (1-4or 5+) Elementary/Secondary (0-12) MARINE BASE MECHANICAL INSPECTOR 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JEAN M. DUNCAN ROBERT EASTON HUNT P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CONSTANCE RAE TODD / DAUGHTER Department of Health 1207 TUCKAHOE COURT, DENTON, MARYLAND 21629 item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or c once. 1 ☐ Burial 2 ICremation 3 ☐ Removal from State FIRST STATE CREMATION 7/19/2010 MILLSBORO, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Livense 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. STACOE Immediate Cause (Final FND Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician ar Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9□Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DYSPHAGIA, ATHERD SCLERDTH 1 Tyes JASCULAR 24a. Was an certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ဥ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: After 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident neral Director: / 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier

22. Name and Address of Facility
WATSON FUNERAL HOME
211 S WASHINGTON ST, MILLSBORO, DE 19966 Approximate Interval Between Onset and Death 10254 23d Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) BIBOHINGDA **ORIGINAL** 

2. Date of Death

23862

4:25

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 XiYes 2 □No

NEW JERSEY

PM

2010

CAROLINE

U.S.A.

Specify:

14 Race - American Indian

WHITE

Black, White, etc.

State Registrar

Medical

(Check only one)

29b. Signature and title of ceptile

31. Date filed (Month, Day, Year)

JUL 1 9 2010

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State State Registrar	of Maryland	•	rtment of Heal <i>ificate of Dea</i>		-	giene Reg. No.!	2010	22062
			Decedent's Name (First, Middle, Last)					2. Date of De		2010	3. Time of Death
	Physicia Medic		Joseph Thomas Hoskins					July 6	, 20	10 Year	6:20 A M
	Examin		4a. Facility Name (if not institution, give street and nu	mber)		4b. City, Town, or Loca	ation of Death			County of Deat	th
~<^			5728 Caroline Avenue  5. Social Security Number 6. Sex	7. Age (In yrs. las	t hirthday)	Rock Hall	Inder 24 Hrs.	8. Date of Birl		Kent	thplace (State or Foreign
	Funeral Director		236-22-3088 1 M 2 F	83	Yrs.		urs Min.	4/17/1	927		untry) WV
	land show dat	tor	10a. State 10b. County	10c. City,	Town or Loc	ation					10d. Inside City Limits
	Mary 28a-1 otifie	Director	MD Kent	Rock	k Hall						1 ¥ Yes 2 □ No
	h the Saor ben	al D	10e. Street and Number			10f. Zip Code			-	izen of What Co	ountry?
	th wif	Funeral	5728 Caroline Ave	edent Ever in U.S.	12 14	21661 as Decedent of Hispani	io Origina (Spec	ify Yea ar No	US		
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Dec Armed F  1 □ Yes  If Yes, G  Year or I	orces? 2 No ive	If	Yes, specify Cuban, Me	exican, Puerto R	Rican, etc.)		14. Race - Ame Black, White Specify: Wh	
Baltimore, Maryland 21215-0036	hour "natur dical	Completed	15. Decedent's Education (Specify only highest grade completed	T	16a. Decede	ent's Usual Occupation and of work done during	most of workin	ag .	16b. Ki	nd of Business	Industry
121	thin 72 ene. than '	Som		1-4 or 5+)	life. DC	NOT use retired)	mod of monan	9	Т		ention
d 2	ed wi Hygie other ent, ti	Be (	17. Father's Name (First, Middle, Last)		Truck	Driver 18.	Mother's Name	(First, Middle,		ansport	ation
<u>la</u>	l be fi fental rked tic ev	မ	Thomas Jefferson Hoski	ns		1	Mercy El	lla Tho	mas	·	
ary	should and N is ma		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing	Address (Street and N	lumber or Rural	Route Numbe	r, City or	Town, State, Zip	o Code)
Σ	nd 2 s lealth m 27		Elizabeth Jackson/Daug			ox 523 Ches	ster, M	21619			
Ore	ge 1a nt of H : If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from	n State cer	netery, crem	ition (Name of atory or other place)		ate		ocation - City or	
₫	nit. Pa artmel ortani injury		4 Donation 5 Other (Specify)  21. Signature of Foneral Service Licensee	Ches		e Cremation Name and Address of F		2010	Ste	vensvil	Lie, MD
Ba	Depart Imperany any		Kut of gelf	ben)	Fe 13	llows, Helf O Speer Rd.	fenbein Chest			Tuneral 21620	Home
			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on e	caused the death. ach line.	Do not enter	the mode of dying, suc	ch as cardiac or	respiratory an	rest,		Approximate Interval Between Onset and Death
	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	ung C	arcir	OMS					Offiset and Death
	Examiner		Due to	(or as a nseque	nce on:						
9		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	(or as a conseque	nce of):						
	cuted	Examiner	Cause (Disease or injury that initiated events C.	(or as a conseque	nac of						
	icate be executed physician and s the burial-transit	salE	resulting in death) Last Due to	(or as a conseque	nice org.						
760	cate to physic sthe l	edical	d								
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transitions.	Physician/M	in the past 12 months?	utcome of pregnance Birth 2  Fetal of gnant at time of dea known	death 3 🗌	Ectopic pregnancy Other (specify)				23d. Date of de Month	livery Day Year
P.0.	that the	by Ph	Part II. Other significant conditions contributing to		_	, ,		23e. Did to	obacco u	se contribute to	the cause of death?
l'S	juires t	ed p	(5600), coroning &	isease,	rzerg	ate cance	£,	1 🗆	Yes 2	<b>(</b> No 3□P	robably 4 🗌 Unknown
COL	aw rec as bee 2 sho	Completed	rend insufficiency,	Diabet	es s	pine steno	sis	24a. Was			topsy findings available completion of cause of
Re	The la	Con			,	0		perfo	rmed?	death?	s 2 🗆 No
ţ	ician: certific ector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1			Other:	f Death (Check	1		-	
<u>&gt;</u>	Phys r this eral dii	e: 10	27. Manner of Death 28a. Date		R/Outpatient 8b. Time of	3 Li DOA 4		ne 5 Resid		Other (Spec	eify)
N C	nding ath. r; Afte e fune	icate	1 Natural 5 ☐ Pending (Mo 2 ☐ Accident Investigation	nth, Day, Year)	i <b>n</b> jury	work? M 1 ☐ Yes					
Division of Vital Records, P.O.	il or Atter after dea Director	Certificate:	3 Suicide 6 Could not be 28e. Place	e of Injury - At hom ling, etc. (Specify)	ne, farm, stre	et, factory, office	2	8f. Location (S City or Tow			ral Route Number,
۰	Hospits 4 hours Funeral ted filler	Medical	29a. Certifier Certifying Physician: To the 2 Medical Examiner: On the bar	asis of examination a	and/or investi	gation, in my opinion, de	ath occurred at t	the time, date a	ind place,	and due to the	cause(s) and manner stated.
	o the	Ĕ	only one) 3 Certifying Nurse Practioner 29b. Signature and title of certifier	: To the best of my k	knowledge, de	eath occurred at the time 29c. License num		, and due to th		) and manner as e signed (Montl	
	E SEO			MO		Da	55173	5	7	1/6110	
			30. Name and address of person who completed car	use of death (Item 2	23a) (Type, Pr				イワ	2167	0
	T m	te	31. Date filed (World, Day, rear)	Redistrar's Signatur	re	41		, ,		_ ,	
	Registra		JUL 1 2 2010	Redistrar's Signatur	1. A	avor					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. N. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10 Day Physician/ Huffman 2010 Eli Troy Medical 4b, City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner WMHS Regional Medical Center umberland Allegany If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 04/23/1925 1 X M 2 D F 85 235-32-7086 Director West Virginia Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits rral", or items 23a or 28a-f sho Examiner must be notified at Director MD Allegany Cumberland 1 Yes 2 X No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral USA 11403 Old Mt. Pleasant Road, NE 21502 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. "natural", or þ 1 Never Married 2 X Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced White traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the May injury or other traumatic event, the May injury or other traumatic event, the May injury or other traumatic event, the May injury or other traumatic event, the May injury or other traumatic event, the May injury or other traumatic event, the May injury or other traumatic event, the May injury or other traumatic event, the May injury or other traumatic event, the May injury or other traumatic event, the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumatic event the May injury or other traumat Bakerv 12 Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Calvin Juffman Judy Jordan Chlorie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Route 1 Box 169H, Keyser, WV 26726 19a. Informant's Name/Relationship (Type, Print) Route 1 Box 169H, Keyser, WV Judith H. Thompson / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Sunset Memorial Park 07/15/2010 Cumberland, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. of Funeral Service Lic 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Year Month Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown been signed by the should be detached 9 Unknown P.O. that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 N death? certificate 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification placed filled in by the funeral director; I Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 \sum Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Marylar		artment of H <i>tificate of D</i>			giene Reg. No.	2010	23865
	Physicia	n/	1. Decedent's Name (First, Middle, Las	t)				Date of Dea     Month		Year	3. Time of Death
	Medic	al	Linda  4a. Facility Name (if not institution, give	Kay		Hampton 4b. City, Town, or		July 1	2, 201	Ounty of Death	2:30 P M
- A	Examin	er	17426 Oldtown Ros				.dtown			llegan	у
	Funeral Director		217-02-0043	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 05/31/	1960	g. Birthp Count Mar	lace (State or Foreign ry) yland
	at at	'n	Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				1	0d. Inside City Limits
	Maryla 28a-f otified	irect	MD Alle	gany		Oldtow	m				1 ☐ Yes 2 🌠 No
	s 23a or ust be n	Funeral Director	10e. Street and Number 17426 Oldtown Ro	oad, SE		10f. Zip Code	21555		10g. Citizen	of What Coun USA	try?
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene.  any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Vas Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 💢 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - America Black, White, e ecify:	
21215-0036	72 hour	Completed	15. Decedent's E (Specify only highest gra		[ (Give	dent's Usual Occupa kind of work done di		ing	16b. Kind o	of Business Inc	lustry
212	within jiene.		Elementary/Seconday (0-12)	College (1-4 or 5+)	1	o <i>not use retired)</i> ified_Nur.	sing Assi	istant	State	e Gover	nment
pu	e filed intal Hyge ed othe	To Be	17. Father's Name (First, Middle, Last) Walter H	loward	Shafi	fer	18. Mother's Name		_{Maiden Surn} Janet	name)	Browning
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Ž	and 2 states a tealth a sm 27 is m 27 is her tra		D. Kevin Hampton			O. Box 43					
nore	age 1 a ent of H nt: If ite y or ot		20a. Method of Disposition  1  ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	cemetery, cren	osition (Name of matory or other place is Cemete	e)	Date 6/2010		ion - City or To erland	·
Baltimore, Maryland	permit. P Departm Importar any injur		21. Sign tu of Funeral Service of s	neral	Home, P.A. 21502						
			23a. Part 1. Enter the disease, or companion shock, or heart failure. List only o	plications that caused the dea							Approximate Interval Between
. P	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a Ovaci	عم د	nec	metas	tetis			Onset and Death
V.	Examiner			Due to (or as a consec	uence or):						
	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a consec	uence of):						
	cate be executed physician and the burial-transit	Exal	that initiated events resulting in death) Last	C. Due to (or as a consec	uence of):						
09	ate be on the physicial the bur	edical	•	d		-					
Division of Vital Records, P.O. Box 68760	ath certific attending for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1  Live Birth 2  Fei 4  Pregnant at time of 9  Unknown	al death 3	Cther (specify)	у		23d.	. Date of delive Month	ery Day Year
s, P.O.	requires that the de been signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	underlying cause giv	en in Part I.				e cause of death?
Secord	or Attending Physician: The law requate requater detector. After this certificate has been in by the funeral director, page 2 shou	Completed						24a. Was a autop perfor	rmed?	4b. Were autop prior to cor death? 1 \(\sum \) Yes	osy findings available mpletion of cause of
ta	ician: Dertifica ector, p	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:		- Othe	ace of Death (Check	k only one)			
of V	g Phys er this eral dir	e: To	27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of injury (Month, Day, Year)	28b. Time of injury	nt 3 ∐ DOA	4 ∐ Nursing Ho at	ome 5 Resid 28d. Describe h			)
ion	tendin Jeath. tor: Aft the fur	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b	1		M 1 🗆	Yes 2□No	006 1		umbay ay Dural	Pouts Number
Sivis	al or At s after ( I Directed in by		4 Homicide determined	28e. Place of Injury - At h building, etc. (Specii	y)	eet, factory, office		28f. Location (S City or Tow		imber or nurar	noute Nuttiber,
_	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completed filled in by the	Medical	(Check 2 Medical Exami	sician: To the best of my know iner: On the basis of examinations se Practioner: To the best of m	on and/or inves	tigation, in my opinio	n, death occurred at	t the time, date a	nd place, and	d due to the cau	use(s) and manner stated.
_		_	29b. Signature and title of certifier			29c. License				gned (Month, L	
	5/2		30. Name and address of person who	completed cause of death (Ite	n 23a) (Type F		66439		- Ju	ly 13,	2010
	TIRS		Blanche Mavromat	is, M.D., 12	502 Wi	llowbrook	RD, Ste	300, Ct	umberl	and, M	D 21502
	Sta Registr		31. Date filed (MoJULay, Tea 20	32. Registrar's Signa	1. Soa	eled					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROY WADDELL HOOTEN 3827PM luli Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Prince George's Doctors Community Hospital Lanham . Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) 8 Date of Birth Days Hours 1 M 2 D F Dec. 8.1918 Virginia 91 Director 578-18-9341 ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Maryland| Lanham 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7017 Saint Anne's Avenue 20706 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, "natural", or iter Armed Forces?

1 X Yes 2 No
If Yes, Give WW Black, White, etc. þ 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examit White 1 ☐ Yes 2 X No Specify: Year or Dates. WII Specify Completed 3 Widowed 4 Divorced Baltimore, Maryland 21215-00 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Law Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sydney Ethel White James B. Hooten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 7017 Saint Anne's Avenue Lanham, Maryland 20706 Florence E. Hooten -wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 7/17/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Bonala V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 U 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ YOCARDIAL INFARCTION disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b Was decedent pregnant 23d Date of delivery Live Birth 2 Live land 2 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 2 🗌 No is certificate has been signed by the a director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 💢 No ျှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this α completed filled in by the funeral dir After this 28a. Date of injury (Month, Day, Year) Certificate; 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work' 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and one investigation, in my spiriture, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Malik

31. Date filed (Month, Day, Year)

6504

Kenilworth Avenuz Suite 200, Riverdale, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2010 Geovanna /Medical 4c County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital Chever / Year If Under 24 Hrs.
Months Days Hours Min. George's rince George's Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 07-25-7. Age (In yrs. last birthday) Social Security Number Funeral Year) 1 □ M 2 🗗 F Months Maryland NONE Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show of Heatth and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Madical Examinat must be notified at 1 DYes 2 □ No Director 10g, Citizen of What Country? 10f Zip Code 10e. Street and Number 2072 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or iter 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Intant None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ Elmer Geovannu Pages 1 and 2 should nent of Health and Mer 19b. Mailing Address (Street and Number or Rural Route umber, City or Town, State, Zip Code) 19a. Informant's Name/R ionship (Type. Print) Terimiah Lane Bowie MB 15009 2072 Ericka 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If it any Injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Prince Georges HOSP 4 Donation 5 ØOther (Specify) Hosp. Dis 21. Signature of Funeral Service Lions e Prince ocorges t 3001 Hospital De Hospital Center Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Prematurity Physician /Medical Examiner Premature Puppure of Membranes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, attending physician Physician/Medical ţ, signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 - Ectopic pregnancy Month Year 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ğ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy perform certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ္ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

State Registrar (Check only one)

29b. Signature and title of certifie

D69577

3001 HOSPITAL DRIVE CHEVERLY, MD 20785

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10-05290 Ryvell Jones Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 23868

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		1- For State Registrar		Certificate	of Dea	ath		., 9.00	Reg. No.		
Physic Medical Exam			Jones					2. Date of De Month July 14, 2	Day	Year	3. Time of Death 1808 hrs
	H	4a. Facility Name (if not institution, gingle Calvert Memorial Hospita	l		Prin	ce Fred			4c. Col Calv	unty of Death e <b>rt</b>	
Funeral Director			ex 7. Age (li	n yrs. last birthday	y) If Un Mon Yrs.	ths Day			irth(MM/DD/) 3 / 1 9 9 :	Foreign	hplace (State or n intry) MD
J iow any		Usual Residence of Decedent		c. City, Town or L							10d. Inside City Limits 1 Yes 2 X No
ie Maryland or 28a-f show any Ited at once.	Director	10e. Street and Number 8316 Evergre			10f. Z	ip Code 2065			10g. Citizen d		
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral [	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Eve Armed Forces?		Was Deced	dent of His		Specify Yes or Noto Rican, etc.)	o- 14. F		an Indian, Black,
ours after d	\$	3 Widowed 4 Divorced 15. Decedent's Education (Specify o	1 Yes 2 X If Yes, Give Year or Dates; nly highest grade comple	ted) 16a. Dece	edent's Usua	al Docupa	specify:	f work done		city: B1a	
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timore Pages 1 ment of H tant: If it		1 Surial 2 Cremation 3 4 Donation 5 Other Specify.		Young '	r other place s Cem	ete:	ry 7/2	22/2010	Hunt	ingto	own, MD
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Box 68760, e death certificate but the attending physical for use as the but	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of  1 Live birth  4 Pregnant at time  9 Unknown	2	Fetal death Other (Spe		Ectopic pregn	ancy	23d. Date Mont	e of delivery h Da	y Year
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Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?	ospital:				of Death (Check	1 Yes	2 NO	1 Yes	2 No
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ivision or Attendii after death. Director: A	ertification:	1 X Natural 5 Pending Pending Investigation 3 Suicide 6 Could not be	on 28e Place of Injury	At home, farm, s	treet, factory		es 2 No	28f. Location (S	Street and Nu	mber or Rura	Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	O	4 Homicide determined  29a. Certifier (Check only 1 Certifying Physicia	(Specify) an: To the best of my kno	wledge, death oc	curred at the	e time, da	te and place, and	or Town, S	e(s) and man	ner as stated	
To the within To the comple	Medical	one) 2 Medical Examiner: 29b. Signature and title of certifier	On the basis of examinat and manner stated	ion and/or investi		y opinion, c. License		at the time, date a		d due to the digned (Month	
		30. Name and address of person who o	ompleted south	7 )		O.C.N			July 15,		, , , , , , , , , , , , , , , , , , , ,
		Russell Alexander MD.	Assistant Medical E	xaminer 1	11 Penn S	Street,	Baltimore, M	D 21201			
St Regist	ate	31. Date filed (Month) 12 (	32. Registrar's Si	gnature	arkel	2					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2010 16:55 P M 9, Florine June Jones July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Western MD Regional Medical Center Cumberland Allegany 9. Birthplace (State or Foreign Country) Pennsylvania 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/07/1926 **Funeral** Months Hours Days 211-18-1767 84 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expression must be notified at PΑ Bedford Director Clearville 1 ☐ Yes 2 🔀 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 810 Town Creek Road 15535 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 X No 1 Never Married 2 T Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clovd Zelda Watkins Lillius Margaret Black ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 810 Town Creek Road, Clearville, PA Glenn S. Jones / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Prosperity Christian Cem 07/13/2010 Hewitt, PA 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Sgnarure of Funeral Sen 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** da /Medical ue to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to or as a consequence P.O. Box 68760 attending physician Physician/Medical the as nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a ☐Yes 2 No 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Ď 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate RMIC 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation ithin 24 hours and the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal within 24 ho

To the Fune

completely f and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0061406 July 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12502 Willowbrook Rd, Ste 580, Cumberland, MD 21502 F Bielec, M.D., Julie 31. Date filed (Month, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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the deat by the at ached fo	by Physician/Medica	1 Yes 2 9 Unknown		4 ∐ Preg 9 □ Unk		me of deat	h 5∐	Other (sp	ecify)					Mor	ntn	Day	Year 
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DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ALLEN **JEFFERSON** LLOYD 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** taston albot Memorial Hospital @ If Under 1 Year If Under 24 Hrs. 6. Sex 1 X M 2 □ F 9. Birthplace (State or Foreign 8. Date of Birth Funeral (Month, Day, ec. 3. Country)
WashingtonDC Days Hours 219-90-9542 44 Yrs. **Director** Dec Usual Residence of Decedent 28a-f show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Talbot 1 ☐ Yes 2X☐ No Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8806 Swann Haven Road 21601 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. à 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 \$\fomathbb{Y} No Specify: White Specify: Completed 3 Widowed 4 X Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hardee's Restaur. Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norma L. Lloyd Thomas Edward Lloyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 111 Liberty Rd. Federalsburg, 21632 Thomas E. Lloyd/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 
Burial 2 
Cremation 3 
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) First State Cremation Ctr. 7/16/2010 | Millsboro, Delaware Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, Federalsburg, 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line ardio Vascular Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner milase Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Kalemia attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year 2 No Yes g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Disease Artery 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 🗌 No 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mohan D0069567 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2195. Washington St. Easton, MD 21601 Mohan.

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Registrar

legistrar's Signature

JUL 1 8 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8 20A Month Physician/ 2010 Carolyn Farr Lynch Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Anne Arundel Tate Hospice House Linthicum If Under 1 Year If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday) 83 Yrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🕱 F Hours Min. Director 255-30-2499 1927 Georgia Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. tant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 925 Boom Way 21401 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White Specify: 3 ☐ Widowed 4 🔀 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Agent Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Elizabeth Cliatt Russell Farr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2609 Lighthouse Lane Baltimore, MD 21224 Cary Lynch / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7.10200 Metro Crematory, INC. Baltimore, MD 21 Sinatur of Funeral Service License Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Highway Severna Park, MD 21146 Part . Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disse or condition resulting in death) Onset and Death Ph_sician/ MUNHOMA Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): has been signed by the attending physician and e 2 should be detached for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should I 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? After this certificate I Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 62 Other (Specify) 2-1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?

1 Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5  $\square$  Pending 1 Natural 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be after death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifie

STANRY 31. Date filed (Month.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

BESTON

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 | 0 23873 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Merrill David Lambert Month 5:10 P M July 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Davidsonville Anne Arundel 1276 Cosgrove Drive 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min 89 **Director** 215-14-6282 Virginia 1/11/1920 West Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Davidsonville 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or Funeral USA 21035 1276 Cosgrove Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 © Yes 2 No 1943-Black, White, etc. 1 X Yes 2 If Yes, Give Year or Dates þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 Divorced Specify: Completed 1945 White er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) hattand Mental Hygiene. n 27 is marked other than er traumatic event, the Mr Elementary/Seconday (0-12) College (1-4 or 5+) Structural Steel Operating Engineer 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Simmons Orgle Lambert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1276 Cosgrove Drive, Davidsonville, MD Richard Lambert / Son Department of Health Important: If item 27 any injury or other ti 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Cumberland Crematory 07/15/2010 Cumberland, MD 4 Donation 5 Other (Specify) Signature of Funeral Service 22. Name and Address of Facility Alams Family Funeral Home, 404 Decatur Street, Cumberland, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending housing and sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year Pregnant at time of death 5 Other (specify) 2 🗌 No g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 s autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural injury 5 Pending Accident Investigation 1 Yes 2 No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title 29d. Date signed (Month. Day. Year) 42010 040733 10+ 30. Name and address of person no completed cause of death (Item 23a) (Type, Print)

Registrar

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31. Date filed (Month, Day, Year)

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62. Registrar's Signature

2322 State of Maryland / Department of Health and Mental Hygiene 20 23874 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **ዕ**′ን"/ 1 1 / 1^Dዕ Rosalind Maxine Lavender 11:22pm^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Maryland **Director** 578-74-4441 04/12 Usual Residence of Decedent or 28a-f show a notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director DC Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ៦ 10g. Citizen of What Country? "natural", or items 23a o Funeral 2311 with Green Street SE #301 20020 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. þ 1 Never Married 2 Married Black 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed W Divorced er than "natura , the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Nurse marked other Be 17. Father's Name (First, Middle, Last) timore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) ည Helen Dove Wilbert Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 permit. Page 1 and 2 s April Lavender Daughter 2311 Green Street SE#301 Department of Health Important: If item 27 any injury or other trong once. Washington, DC 20020 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 07/19/10 Riverdale, Maryland Riverdale 4 Donation 5 Other (Specify) Signature of Funeral Service Licen 22. Name and Address of Facility Snead Mortuary Service, P.A. 0777 1409 Fairlakes Pl Ste B Mitchellville,Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final acute myocardial Physician/ infarction disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner atheroscleratio coronal disesse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death 5 Other (specify) Month Day Year be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 s this certificate has performed? Yes 2 N 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 1 Yes 2 No မ 1 Inpatient 2 K ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at iniury Natural 5 Pending work?
1 Yes 2 No Accident Investigation 124 hours after deat • Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058025 July 11,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WENK, JONATHAN MD 9901 Medical Center Dr Rockville, Md 20850 31. Date filed (Month, Day, Year) Registrar's Signature 2010 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 William L. Morris Jr. 3:06 P Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Gilchrist Hospice Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min, **Funeral** 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth g. Birthplace (State or Foreign 219-07-8405 **Director** 94 Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Howard West Friendship 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3320 Pfefferkorn Rd 21794 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? 1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Divorced 4 Divorced Year or Dates. WWII Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Lab Technician Research Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William L. Morris, Sr. Nellie M. Highlander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Leona Drive Greer, SC 29651 <u>Paul M. Morris - Son</u> 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 7/19/10 Crest Lawn Mem. Gdns Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke s Family F.H. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ CHI disease or condition years Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. (Pierre Underlying Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or iinjury that initiated events signed by the attending physician and d be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been significate has been significated and a funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 🗌 Yes 2 No Yes 2 No Director; After this certification by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital: Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 Natural work? 1 🗆 Yes 2 🗆 No 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined building, etc. (Specify) To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number MD 00070635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laura Patel 701 4105 Baltimore, MD N Charles

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Registrar

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2010 23876 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Elsie Bowen Marshall 3:30 2010 Tulv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Medical Anne Arundel Center 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Date of bills.
(Month, Day, Year)

20, 1920 **Funeral** 1 □ M 2 🛛 F Months Hours Maryland 215-18-0242 90 Director Usual Residence of Decedent items 23a or 28a-f show 10b. County 10a, State 10c. City. Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at Director Severna Park Anne Arundel MD 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21146 348 Stonehouse Drive within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status 1 Never Married 2 Married ò þ ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify: If Yes, Give "natural", 3 XWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MVA Title Examiner 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked Annie M. Hall Leland H. Bowen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 348 Stonehouse Drive Severna Park, MD 21146 Phillip S. Marshall Date 15, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July Metro Crematory, Baltimore, MD injuny INC: 2010 21. Signature of Eurieral Service Licensee Name and Address of Facility P.A. 22. Name and Address Barranco Severna Park Funeral Home any 495 Ritchie Highway Severna Park, MD 21146 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Deat Immediate Cause (Final Physician/ ninu disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and -transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last burial-t attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregr 23d. Date of delivery in the past 12 months Month Dav 4 Pregnant 9 Unknown 5 Other (specify) Pregnant at time of death signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed as been signal 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page performed 2 🗆 No this certificate 1 Yes Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) funeral director, Be Other: 2 No 1 Inpatient 2 NER/Outpatient 3 IDOA 1 Yes မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After injury Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu death. 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatur title of certi 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, State Registrar

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			State Registrar  1. Decedent's Name	(First Middle Lo	ot)		Cei	tificate of D	eath	1	Reg. No. 20	10	23877
	Physicia Medic		Peter Edw	ard Med	ley, Jr.		<u>.                                      </u>			2. Date of De Month	8/2010 '		3. Time of Death 0026 M
	Examin	er	4a. Facility Name (if no Anne Arun					4b. City, Town, or		th	4c. County		udo 1
- 10	Funeral		5. Social Security Nur	mber 6. 5	Sex 7. A		ast birthday)	If Under 1 Year	napolis If Under 24 Hrs		Anne		place (State or Foreign
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ylar	Id be Menta narkec atic e	욘	Peter E.						Ann I	[ppolito			
Maryland	shou hand 7 is m traum		19a. Informant's Nam					ng Address (Street a					iode)
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OE I	Page nent o		1 🗌 Burial 2 🛭 4 🗐 Donation 5		Removal from Sta			natory or other place Crematory	y 7/1	10/2010	Glen Bu	-	
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other:		21. Signature of Fune	eral Septim Licen	see	•	Funeral l		P.A.				
			23a. Part 1. Enter the shock, or heart	e disease or com	plications that caus	ed the deatl						+01	Approximate
2	Pnysician/	6 8	Immediate Cause (Findisease or condition		9			occucul	JEI	2120			Interval Between Onset and Death
-	Medical Examiner		resulting in death)		Due to (or a	s a consequ	ience of):		,				
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Box 687	ath certificate be executed attending physician and for use as the burial-transit	M/ne	IF FEMALE: 23b. Was decedent pr		23c. If yes, outcom	e of pregna	ncy	Ectopic pregnancy			23d. Date	e of delive	ry
_	the atte	Physician/M	in the past 12 mo 1  Yes 2 9  Unknown		4 Pregnant 9 Unknowr	at time of c		Other (specify)			Mor	nth	Day Year
P.0	s that the deagned by the a	by	Part II. Other signification	ant conditions	ontributing to death	but not res	ulting in the u	nderlying cause give	en in Part I.		obacco use contri	bute to th	e cause of death?
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/ital	Attending Physician: er death. ector: After this certific by the funeral director,	To Be	25. Was case referred examiner?  1 Yes 2		Hospital:	ationt 0	ER/Outpatien	Other	ce of Death (Che		dence 6 🗆 Othe	<b>6</b> 0 (6)	
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ion	tendir leath. tor: Af the fur	Certificate:	2 Accident	5 ☐ Pending Investigatio 6 ☐ Could not b	n ne			M 1□Y	∕es 2 □ No				
Division	al or Attenos after deat I Director: d in by the		4 Homicide	determined	28e. Place of Ir	njury - At ho etc. (Spec <i>ify,</i>	me, farm, stre )	et, factory, office		28f. Location (: City or Tox	Street and Numbe vn, State)	r or Rural	Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	Medical	(Check 2 L	Medical Exam	sician: To the best of iner: On the basis of se Practioner: To th	examination	and/or invest	igation, in my opinior	, death occurred	at the time, date	and place, and due	to the cau	se(s) and manner stated.
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	10×1		30. Name and address	s of person who		death (Item	23a) (Type, P	rint)	Δ	20160	md	214	10
	Stat		31. Date filed (Month.		-	trar's Signat	ure	1 Br KWI	<u> </u>	John 1.	1	0. 1	
	Registra	ır'	JUL 1	1 0 2010	Lenne	p.	graves						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend#2 per Phy

7/14/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23878 Reg. No 2 0 1 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** CHARLES MILLER 2217 0 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** WESTERN MO MED, CENTER CUMBERLAND ALLEGANY 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5 Social Security Number 8. Date of Birth (Month, Day, Year) 6 Sex **Funeral** 1 M 2 □ F Months Days Hours Min 183-40-0504 Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. Widon Evan. BENFORD HUNDMAN 1 ☐Yes 2 ☐No **Funeral Director** 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ROAD USA 112 MAGNOLIA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1971 - 72 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LONSTRUCTION EQUIPMENT MAINTENANCE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOHN CHARLES MILLER SR CAMPRELL MILDRED 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA C. MILLER WIFE HYNDMAN PA 15545 112 MAGNOLIA RD 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 7-17-2010 HYNDMAN HUNDMAN CEM. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HARVEY H. ZEIGLER FUNERAL 21. Signature of Funeral Service Licenses HUMEING 169 CLARENCE ST. HUNDMAN PA 1654S 23a. Part 1. Enter the disease, or shock, o heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** FEB. 2016 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner requires that the death certificate be executed and use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year 5 Other (specify) P.0. 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 ✓ No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performed?

1 Yes 2 No certificate ! 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 🗷 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of pe

31. Date filed (Month, Day, Year) JUL 19 2010

TAMAN

QUMAR

MONSOZ Willowbrook Rd soite 440 comberland MD

en who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Ma	aryland / [	•	artment of F <i>tificate of L</i>		Mental F		1e No.201	Ω	23879
			Decedent's Name (First, Middle, La	ist)					2. Date of	Death			3. Time of Death
	Physicia Media		Lela H. Mead						July		Day Ye 13 201	ar 0	11:25 A ^M
	Examir	ner	4a. Facility Name (if not institution, giv	e street and number)			4b. City, Town, or		ath	-	4c. County of E		
نصر			13016 Meadowview 5. Social Security Number 6.5	W Dr. Sex 7. Age	e (In yrs. last birt	hdayl	Gaither  If Under 1 Year	sburg	s. 8. Date of	Dist	Montgo		<u> </u>
	Funeral Director			1 □ M 2 🖽 F	89		Months Days	Hours Mir		Day, Year 18 19	321	Countr	ace (State or Foreign y) Oregon
	nd how at	ž	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Loc	ation	-				10	Od. Inside City Limits
	faryla Ba-fs tified	Funeral Director	MD Montgo	omerv	Gaith	ers	burg						1 ☐ Yes 2 🔯 No
	the h	ā	10e. Street and Number				10f. Zip Code			10g.	Citizen of What	t Count	ry?
	n with	nera	13016 Meadowview	v Dr.			2087	8		Ur	nited S	tate	es
36	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.	ever in U.S. No	If	Vas Decedent of H Yes, specify Cuba ☐ Yes 2X No	n, Mexican, Pue	Specify Yes or I rto Rican, etc.)	No-	14. Race - A Black, W Specify:	Vhite, et	
Š	hours natur dical f	lete	15. Decedent's	Education	16a.	Deced	ent's Usual Occup	ation		16b.	I . Kind of Busine	ess Indi	ustry
Maryland 21215-0036	thin 72 ine. than "	Completed	(Specify only highest g	College (1-4 or 5	i+)	life. DO	ind of work done of NOT use retired)	luring most of w	orking				
i D	ed wit Hygie other ent, th	Be	17. Father's Name (First, Middle, Last)	4	J	H	omemaker	18. Mother's N	ame /First Mide	dle Maide	Own Hot	ne	
a	l be fil lental rked c	卢	Ray Henderson						ed Meye	•	in Garriario,		
ary	12 should be file alth and Mental H 27 is marked o r traumatic eve		19a. Informant's Name/Relationship (	Type, Print)	19b	. Mailin	g Address (Street	and Number or F	Rural Route Nun	nber, City	or Town, State	, Zip Co	ode)
∑ ∑	ind 2 sealth im 27		Sterling Mead/S	Son			Edgefie:	ld Rd. E	Bethesda				
50	ge 1 a nt of H : If ite or ott		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemeter	ry, crem	sition (Name of natory or other plac		Date		Location - City		,
	artmer artmer ortant injury		4 ☐ Donation 5 ☐ Other (Specal 21. Signature of Funeral Service Licer		M01463		oln Crema  Name and Addres					1, M	faryland _
Eg/	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once.		Signature of Fullerar get vice Licer	1566			040 Rocks					208	352
			23a. Part 1. Eviter the disease, or con shock, or heart failure. List only Immediate Cause (Final	nplications that caused one cause on each line	the <b>d</b> eath. Do n	ot ente	r the mode of dyin	g, such as cardia	ac or respiratory	arrest,			Approximate Interval Between
	Medical		Immediate Cause (Final disease or condition resulting in death)	a Dia	betes M	e11:	itus					1	Onset and Death
	Examiner				ebrovas		ar Accide	ent					
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	a consequence o	of):							
	executed an and rial-transi	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Coro	nary Ar	tery	y Disease	<u> </u>				+	
<b>5</b>	cate be executed physician and the burial-transit	edical E	rooding wasdany East.		ricular		topv						
2/60	certificate be inding physicia use as the bur	Med	IF FEMALE:	_ u							1		
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  Within 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Fetal death		Ectopic pregnand Other (specify)	у		_	23 <b>d</b> . Date of Month		'Y Day Year
J.	that the ned by a detail	by Pt	Part II. Other significant conditions	contributing to death b	ut not resulting i	n the ur	nderlying cause giv	en in Part I.	23e, Di	id tobacco	o use contribut	e to the	cause of death?
ds,	quires en sig ould b								. 1	Yes	2 <b>₭</b> No 3	Proba	ably 4 🗆 Unknown
Division of Vital Records,	The law re ate has be page 2 sho	Completed							p	/as an utopsy erformed? es 2 🔀	prior deat	to com	sy findings available upletion of cause of
<u>ta</u>	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			26. Pl	ace of Death (Ch	eck only one)				
<u>&gt;</u>	Phys r this ral dir	는 일 일	1 Yes 2 XNo  27. Manner of Death	1 Inpatie	ent 2 ER/Ou ry 28b. T	tpatien	t 3 DOA 28c. Injun	4 ☐ Nursing	Home 5 R		6 Other (S	pecify)	
ב	nding ath. r: Afte e fune	icat	1   Natural 5 □ Pending 2 □ Accident □ Investigation	(Month, Day	<i>r, Year)</i> ii	njury	work	? Yes 2□No	EGG. EGGGIA	20 110 tt 111	ary occurred		
DIVISION	tal or Atte Irs after de al Directo led in by th	al Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		iry - At home, fai c. (S <i>pecify)</i>	rm, stre	et, factory, office			n (Street a Town, Sta	and Number or ite)	Rural F	Route Number,
	the Hospi hin 24 hou the Funer appleted fill	Medical	(Check 2 ☐ Medical Examonly one) 3 ☐ Certifying Nu	ysician: To the best of niner: On the basis of e rse Practioner: To the	xamination and/o	r investi	gation, in my opinio eath occurred at the	on, death occurred e time, date and p	d at the time, da	te and pla the caus	ce, and due to te e(s) and manne	the caus r as stat	se(s) and manner stated. ted.
_	2 × 2 (5)		29b. Signature and title of certifier	idma	11) -	M	29c. License				Date signed (Me	onth, Da	ay, Year)
	~		30. Name and address of person who	completed cause of d	eath (Item 23a) (	Type P	D378	01		/,	/14/10		
			A. Seidman 15020	Shady Gro	ve Road,	#3	00 Rockv	ille, M	20850				
	Sta Registr		31. Date filed (Month, Day, Year) <b>JUL</b> 16 201	2. Registra	r's Signature	fack	W.						

DHMH 17 Rev 7/2009

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State of Maryland / Department of Health and Mental Hygiene

		For State Registra	ND#24a,26,	State of M 29cpenMF,7-16								201	0	23880
Physicia	n/	1. Decedent's Nam	e (First, Middle, L	.ast)						2. Date of De Month			Year	3. Time of Death
Medic	al		Ritzberg				# 6" T	.1	(D. #	July 6	,201	Ĺ0		5:55 P M
Examin	er	Casey		ive street and number)			4b. City, Town, o		on of Death			. County o		
Funeral		5. Social Security N		Sex 7. Ag	e (In yrs. la	ast birthday)	If Under 1 Year Months Days		der 24 Hrs.	8. Date of Bir (Month, Da	th			lace (State or Foreign
Director		096-24-4 Usual Residence of		T L M Z LA F	78	Yrs.		110011		Nov. 1	7,19	931		<u>York</u>
show dat	tor	10a. State	10b. County		10c. City	y, Town or Loc	ation		-				10	0d. Inside City Limits
Mary 28a-f otifie	irec	Maryland		mery	Roc	kville								1 Yes 2 No
ith the 3a or t be r	rai D	10e. Street and Nur		nue, #401			10f. Zip Code	E 2				tizen of Wi		
eath w	Funeral Director	11. Marital Status	Tanu Ave	12. Was Decedent	Ever in U.S		208 /as Decedent of H	lispanic (			UII	Lted 14. Race		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Man 3 🎇 Widowed	ried 2   Married 4  Divorced	Armed Forces?  1 ☐ Yes 2 🛣  If Yes, Give  Year or Dates.	No		Yes, specify Cuba			Rican, etc.)		Specific	, White, e Afri Amer	can-
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Medical Examiner		disease or condition resulting in death)	1	a. Due to (or as	a consequ	ence of):	Gan	10 rap	yiex-		(5)41	α		MOUTH'S
<b>70 </b> ≒	niner	Sequentially list co if any, leading to in cause. Enter Unde	nmediate erlying	b. Due to (or as	a consequ	ence of):								
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?	1 Live Birth 4 Pregnant a	2 Feta	Ideath 3 🗌	Ectopic pregnand Other (specify)	су				23d. Date Mont		ry Day Year
ires that th signed by d be detac	Completed by Ph	Part II. Other signit	ficant conditions	contributing to death b	out not resu	ulting in the ur	nderlying cause gi	ven in Pa	art I.					e cause of death?
w requ s been s shoul	plete									24a. Was		24b. W	ere autop	sy findings available
Physician: The law this certificate has ral director, page 2	Com									autor perfo 1  Yes	rmed?		eath?	
ician: certific ector,	Be	25. Was case referr examiner?	-	Hospital:			26. P	or:	eath (Check			,		
Phys rr this e	e: To	1 Yes 2	h	1 L Inpati	iry	ER/Outpatien 28b. Time of	28c. Injur	4 🗀		me 5 Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence R				Hospice
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l or Atte after de Directo	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could no determine				et, factory, office			28f. Location (S City or Tow			or Rural I	Route Number,
Hospital 24 hours Funeral sted filled	Medical	(Check 2	Medical Exa	hysician: To the best of miner: On the basis of e	examination	and/or investi	gation, in my opini	on, death	occurred at	the time, date a	nd place	, and due t	to the cau	se(s) and manner stated.
To the within To the comple	Ž	only one) 3 29b. Signature and		urse Practioner: To the	best of my	knowledge, d	29c. Licens			e, and due to th	-	te signed (		
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DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible lnk, Ensure All Copies Are Legible.
Amend 20b per FH G906 8/9/10 dk
State of Maryland / Department of Health and Mental Hygiene

	1	For State Registrar		C	ertificate of	Death		Reg. No.2	110	2388
Physician /Medical	n	1. Decedent's Name (First, Middle, Last John	Morris, I	II			2. Date of De Month	13 2	Year 010	3. Time of Death
Examine		4a. Facility Name (If not institution, give 1133 Market Stree			Dento			4c. Cou		line
Funeral Director		217 34 3730	7. Age ( <i>In yr</i> s.	last birthda Yrs	Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Dec. 25	av. Year)	Cot	place (State or Fore intry) nsylvania
a-f show		Usual Residence of Decedent 10a. State 10b. County  Maryland Carol		ty, Town or Dent						10d. Inside City Lim 1 ☐ Yes 2 ☐
23a or 28	Funeral Director	10e. Street and Number 1133 Market Stree	t		10f. Zip Code 21629	9		10g. Citizen United		_{intry?} es of Amei
0, 10	2	11. Marital Status 1 □ Never Married 2 → Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in L Armed Forces? 1x∏Yes 2 ☐ No If Yes, Give Year or Dates:	I.S. 1	3. Was Decedent of In If Yes, specify Cub 1 □ Yes 2√□ No		pecify Yes or No o Rican, etc.)		Race - Amer Black, White Boify: Cau	
iene. than "natur. he Madical I	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed) College (1-4or 5+)	(G lif	ecedent's Usual Occup live kind of work done fe. DO NOT use retire	oation during most of wor d)	king		f Business/I ilers	ndustry
event, In	Be Co	17. Father's Name (First, Middle, Last)		IV	<u>lechanic</u>	18. Mother's Nan		e, Maiden Sur	name)	
marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked of marked	0	<u>John</u>	Morris, I				Virgini			
and Mer Is marke aumatic		19a. Informant's Name/Relationship (7)		1	ailing Address (Street					
n 27   er tra		Shirley Morris	Wife		33 Market S					.629
ment of Hes ant: If item lury or othe		20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State		sposition (Name of crematory or other pla ol Cremator	ry  7/19	Date / 2010	Dove		laware
Department of Important: If i any injury or once.		21. Signature of Funeral Service Licens  23a. Patrl . Enter the disease, or comp	near		22. Name and Address	Second St	reet, D	enton,		
	cal Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse  b. Due to (or as a conse  c. Due to (or as a conse  d	quence of): quence of):						
g as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) 9 \( \text{Unknown} \)	23c. If yes, outcome of pregr 1  Live birth 2  Fe 4  Pregnant at time of 9  Unknown	al death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		23d	. Date of del	ivery Day Year
igne be d	ò	Part II. Other significant conditions of	ontributing to death but not re	sulting in th	ne underlying cause gi	ven in Part I.				the cause of death
this certificate has been signed by the attendiral director, page 2 should be detached for use	Completed						per 1 □ Yes	opsy formed? 2 No	t4b. Were au prior to death? 1 □Yes	utopsy findings ava completion of caus
certific rector,	Be	25. Was case referred to medical examiner?	Hospital:	7.55/0	o Doc Ot	26. Place of De	,		10th == (0	**·\
th. After this funeral dii	tion: To	1 Ness 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Tin Inju	ne of 28c. Injury	4 ⊔ Nursing i	Home 5 Res	e how injury o		спу)
after death.  I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm	, street, factory, office		28f. Location City or To	(Street and Nown, State)	lumber or R	ural Route Number
unera unera	Medical C	29a. Certifier  (Check only one)  1 Certifying Phy 2 Medical Exam	ysician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, on ation and/	death occurred at the or investigation, in my	time, date and plac opinion, death occ	ce, and due to the curred at the time	ne cause(s) ar e, date and pl	nd manner a ace, and due	s stated. to the cause(s)
e F	4.		Domit	IM.	29c, Licen	ise number		29d. Date s	igned (Mon	h. Dav. Year)
within 24 hours after To the Funeral Dire completely filled in b	Me	29b. Signature and title of certifier	Deuseu	ME	DI	4664	1	J01	V 15	2010

10-05526 Dennis Moore, S Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ennis Moore, Sr.	1- For State	State of Maryland /	Department of Certificate of	Health and No Death	Mental Hy		201	0 23882
Physician/	Registrar  1. Decedent's Name (First, Mi	ddle,Last)				2. Date of Death		3. Time of Death
' ∵al Examiner						Month July 24, 20		0937 hrs
	4a. Facility Name (if not institu	ition, give street and number)	4	b. City, Town, or Loc	cation of Death		4c. County of Dea	ith
	27 Cecil Parkway			Charlestown			Cecil	
Funeral	5. Social Security Number	6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year  Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth	(MM/DD/YYYY) 9. E Fore	Birthplace (State or eign
Director	180-50-7277	1X M 2 F	50 Yrs.		Hours Will.	Dec. 6	, 1959 °	Country) HI
	Usual Residence of Decedent							10d. Inside City Limits
any	10a. State 10b. Cour	ty	10c. City, Town or Locati	on				1 Yes 2 No
nd show	PA La	ncaster	Christiana					1
the Maryland a or 28a-f show lifted at once.  Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ourid y r
uh the Maryland 23a or 28a-f sho notified at once. al Director		11ey Rd		17509			USA	rica Indian Plant
with ms 23 be no	11. Marital Status	12. Was Decedent Armed Forces?		s Decedent of Hispar es, specify Cuban, M	nic Origin? ( Sp lexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am White, etc.	erican Indian, Black,
r death with or items 23 must be no	1 Never Married 2 X	1 Yes 2	X No	Yes 2 No s	if		Specify: W	ri to
s after ral", oiner	3 Widowed 4	Divorced If Yes, Give Year or Dates:	-	t's Usual Occupation		ork done	16b. Kind of Busines	
hours hours Exam	15. Decedent's Education (S	Specify only highest grade com  College (1-4 or 5	during m	ost of working life. Do	O NOT use retir	ed)		
36 nan "	Elementary/Secondary (0-	College (14 of c	· i	ne Operat	or		Plastics	
5-0036 ed within 72 hour lygiene. other than "natu he Medic 1 Ex-n Completed	17. Father's Name (First, Mid	dle, Last)				(First, Middle, M	laiden Surname)	
215- be filed ntal Hy rked of ent, the				j	Jeanne	Acker		
212 ould be ould be d Ment s mark it ever		onship (Type, Print )	19b. Mailing	Address (Street a	and Number or F	Rural Route Num	ber, City or Town, St	ate, Zip Code)
AD 2 sho h and 27 is masti	Robin H. Moo	re / wife	179 U	Jpper Vall	ey Rd.		ana PA 1	7509
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medir. Examiner must be notified at once To Be Completed by Funeral Director	20a. Method of Disposition	ition 3 Removal from Sta	20b. Place of Dispos crematory or ot	sition (Name of cemet her place)	tery, 7/2	Date 28/2010	20c. Location - City	or rown, state
nor ages ant of nt: If	1 A Burial 2 Crema 4 Donation 5 Othe		Upper Oct	orara Cem	netery		Parkesbu	rg, PA
altir nit. F vartme	21. Signature of Funeral Sen	rice Licensee	22.1	Name and Address of	f Facility Funera	1 Home.	P.A Sun, MD 2	
ii ii B	Kechand	1 book	ف1	11 S. Que	en St.	Rising	Sun, MD 2	1911 Approximate Interval
Physician	23a. Part I. Enter the disease	, or complications that caused use on each line.	the death. Do not enter t	he mode of dying, su	ich as cardiac o	r respiratory arre	est, shock, of heart	Between Onset and Death
/Medical Examiner	Immediate Cause (Final dise	ase a Cirrho	sis of Live	<u>r</u>				Doda
^	or condition resulting in deat	h) Due to (or as a cons	equence of):					
	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence of):		-			
	cause. Enter Underlying Ca (Disease or injury that initiat	od C.						
ed and and and and and and and and and an	events resulting in death) La		equence of):					
0, be executed sicion and burial - transit	X UNPENDED	x AMENDED 19	a,per fh,23	a,27 per 1	me g907	9-10-10	) vt	
		23c. If yes, outco			7		23d. Date of deli Month	very Day Year
6876( certificate nding phy ise as the b	23b. Was decedent pregnant past 12 months?	Decement of		etal death 3 ther (Specify)	_Ectopic pregna	ancy	Wionan	Day Tour
box 68760 the death certificate by the attending physiched for use as the box of the cirian Medician M	1 Yes 2 No 9	Unknown 9 Unknown	5 🗌 0	ther (Specify)				
cords, P.O. Box 68760 law requires that the death certificate has been signed by the attending physic should be detached for use as the by the analyted by Physician/Method	Part II. Other significant co	nditions contributing to dear	th but not resulting in the	underlying cause giv	ven in Part I.			e to the cause of death?
P.O. es that the signed by be detac						1Ye	s 2 No 3	
ds, equir						24a. Was autor	osy prior	e autopsy findings available to completion of cause of
Records,  The law requires ficate has been sign, page 2 should be						perfo 1 ✓ Yes	ormed? deat	
tal Rection: The lector, page		edical		26.Place of	of Death (Check	only one)		
Vital I hysician: this certifi al director,	examiner?	Hospital: 1 Inpati	ent 2 ER/Outpatier	nt 3 DOA	other Nursi	ng Home 5	Residence 6 🗸 0	ther: Scene
Division of Vital Records, tal or Attending Physician: The law requir sate death.  a) Director: After this certificate has been s led in by the funeral director, page 2 should be additional or Dea Completors.		28a. Date of Inj (Month, Day,	jury 28b. Time of			28d. Describe	how injury occurred	
on on ath.	1 X Natural 5	Pending			es 2 No			
/iSi or Att rer de rirecte in by t	2 Accident 3 Suicide 6	Could not be 28e. Place of I	njury - At home, farm, str	eet, factory, office bu	ilding, etc.	28f. Location ( or Town,		r Rural Route Number, City
Division  Hospital or Attend 44 hours after death Funeral Director: tely filled in by the	4 Homicide	determined (Specify)						
8 4 8 9 4	_   29a. Certifier 4   Continui	ng Physician: To the best of r	ny knowledge, death occ amination and/or investig	urred at the time, date ation, in my opinion,	e and place, an death occurred	d due to the cau at the time, date	ise(s) and manner as and place, and due	stated. to the cause(s)
To the within 2 To the complet	29b. Signature and title of c	and manner stated	1.	29c. License			29d. Date signed	
	1100	hallane.		O.C.M	ſ.E.		July 25, 2010	
	30. Name and address of p	erson who completed cause of	death (Item 23a)					
	Margarita Korell N			Penn Street, Ba	altimore, MD	21201		
Sta	te 31. Date filed (Month, Day,	(ear) 2010 32 Registr	rar's Signature	Expland				

10-05438 James Kay Nogle Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar Certific	cate of Death	Reg. No.	2388
Physici		Decedent's Name (First, Middle,Last)		Date of Death     Month Day Year	. Time of Death 0755 hrs
dical Exam	ner	James K. Nogle  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	July 21, 2010 4c. County of Death	07551115
		218 Crestview Drive	Thurmont	Frederick	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bit 219–38–5538 1 km 2 F 68	irthday) If Under 1 Year If Under 24Hrs Months Days Hours Min		Marvland
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow	n or Location	110	0d. Inside City Limits
<b>≹</b> ,			rmont	į –	Yes 2 No
th the Maryland 23a or 28a-f show	Director	10e. Street and Number	10f, Zip Code	10g. Citizen of What Country	y?
the M a or 2 tified	Dire	218 Crestview Drive	21788	USA	
n with ms 23 be no	eral	11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?	13. Was Decedent of Hispanic Origin? ( Sp. If Yes, specify Cuban, Mexican, Puerto		n Indian, Black,
15-0036 filed within 72 hours after death with the Maryland I Hygiene. od other than "natural", or items 23s or 28a-f she t, the Medical Examiner must be notified at once	Funeral	1 Yes 2 X No		1- :	+0
rs afte ural", miner	ģ	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a	1 Yes 2 No specify:  Decedent's Usual Occupation (Give kind of v	орголу.	
5-0036 led within 72 hours af Hygiene. other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use reti		aoa,
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	du	4 Bu	us driver	Touring Co	mpany
e, MD 21215-0036 I and 2 should be filed within ' Health and Mental Hygiene. item 27 is marked other than r traumatic event, the Medici		17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surname)	
121 Id be f Aental narke	o Be	Morris Ray Nogle  19a. Informant's Name/Relationship (Type, Print)  19	Lillian  9b. Mailing Address (Street and Number or F	Amabel Harbaugh	in Code)
<b>○</b> 8 5 5 2	<b>-</b> I		ll Thalia Lane, Birds		
imore, MD 2 Pages 1 and 2 shoument of Health and 1 tant: If item 27 is a		20a, Method of Disposition 20b. Place	of Disposition (Name of cemetery, atory or other place)	Date 20c. Location - City or To	
S 25 = 51		1 Danial 2   Cicination 0   Itemoval non otato		-2010 Thurmont, Ma	ryland
Baltimo permit. Page Department of Important: injury or oth		21. Signature of Funeral Service Licensee		uffer Funeral Home	
<b>m</b> 525.		Sharon Gamelle Eline	1621 Opossumtown F	ike, Frederick, Mar	•
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do r failure, List only one cause on each line.	not enter the mode of dying, such as cardiac o	r respiratory arrest, shock, or heart	Approximate Interva Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuri  Due to (or as a consequence of):	es		Death
		Sequentially list conditions,  b.			
	iner	if any, leading to immediate Due to (or as a consequence of):			
	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
760, icate be executed g physician and the burial - transit		d			
60, ate be ex hysician e burial	Medical		8a-f per me g906 8-5-		
. 68760, certificate be executed nding physician and se as the burial - transi	Ž	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy	7 Fetal death 3 Ectopic pregna	23d. Date of delivery ncy Month Day	Year
Box 687  E death certific  The attending p  Ed for use as th	sician/	past 12 months?  4 Pregnant at time of death	5 Other (Specify)		
hed the	主	9 Unknown	ng in the underlying cause given in Part I.	23e. Did tobacco use contribute to the	equipe of death?
P.O. es that th igned by e detach	۵	rart II. Other significant conditions contributing to death but not resulting	ing in the underlying cause given in Part I.	1 Yes 2 ✔ No 3 Probab	
ords, P.C. w requires that as been signed to should be deta	Completed				sy findings available
COL law n has b e 2 sho	nple			performed? death?	pletion of cause of
tal Recian: The certificate ector, page		25. Was case referred to medical	26 Place of Death (Check	Yes 2 No 1 Yes	2No
Division of Vital Records, all or Attending Physician: The law require stafer death. In Inferent After this certificate has been si led in by the funeral director, page 2 should b	o Be	examiner? Hospital: 1 Innation 2 FR/C	Towar —	g Home 5 Residence 6 ✔ Other: So	cene
n of \ding Phy	<b>-</b> -		Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
ION teath. tor: A	ation	1 Natural	:50 am 1 Yes 2 X No	Injured while cutti	ng a tree
DIVISION To the Hospital or Attendi within 24 hours after death. To the Funeral Director:  completely filled in by the fi	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, to	farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural or Town, State) 218 Cresty	Route Number, City
Spital Dours	Cer	4 Homicide determined (Specify) house		Thurmont, Md.	TCW DI.
DIVI To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	ical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de one)  2 Medical Examiner: On the basis of examination and/or			ause(s)
To t with To to	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month,	
)	-	Jan 18 Sent 11 north	O.C.M.E.	July 22, 2010	
	- }	30. Name and address of person who completed cause of death (Item 23a)			
		(1011)			
		Pamela E. Southall, MD Assistant Medical Examine	er 111 Penn Street, Baltimore, N	1D 21201	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Joseph L. Pusateri, Sr. 196^y 20Th 5:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3032 Mullineaux Lane Ellicott City Howard 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 578-38-1100 98 Months Hours M87/20119911 DC. Director Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Howard 1 Yes 2 No Ellicott City 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 3032 Mullineaux Lane United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 XWidowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 2 should be filed within 72 hand Mental Hygiene.
7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government 12 Transportation Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Antonio Pusateri Catherine Cariota 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen J. Pusateri - Son 3034 Mullineaux Lane Ellicott City, MD 21042 1 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 7/21/10 Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 OUX M01411 23a. Part f. Enter the dijease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Congestive Heart Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Hypertension 24ears Sequentially list conditions, if any, leading to minisorate cause. Enter Underlying Cause (Disease or iinjury Examine Dualto (or sels consequence of) burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 the as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director; After this certificate has k autops, performed? autopsy death? 1 Yes 2 🗆 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2/No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Natural
2 Accident 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending М 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 7-19-2010 D 46855 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Columbia, Maryland 21044 Putukent Porkway 10 31. Date filed (Month, State istrar's Signature Registrar

DHMH 17 Rev 7/2009

			For State Registrar		State of Ma	aryiand		tificate of			-	•	<u>8</u> 01	0	23	885
ı	Physicia	an	1. Decedent's Name	e (First, Middle, La	st)						Date of De Month	D		/ear		e of Death
	/Medic			e Louise							July I					00 A M
	Examin	er			e street and number)			4b. City, Town, o					c. County of Prince			2
	Firmural		5. Social Security N	ters Mil		e (In yrs. las	st birthday)	If Under 1 Year			Date of Bir (Month, Da				_	ate or Foreign
	Funeral Director		229-70-0 Usual Residence of	275	□м 2💢 F	64	Yrs.	Months Days	Hours			6, Yea	1946	Nor	th Ca	arolin
	ryland	<u>.</u>	10a. State	10b. County		10c. City,	Town or Lo	cation						1		e City Limits
	e Ma Ba-f s	) Sc	MD	Prince (	Georges	Fort	Washi	Ington			1					Yes 21X No
	th with the 23a or 2	Funeral Director	10e. Street and Nun 1506 Hun		ll Avenue			10f. Zip Code 20744	1				S. A		ntry?	
0000	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, I'm Medical Examinet must be notified at	þ	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	ed 2 X Married 4 Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cub I □ Yes 2 1 No			iy Yes or No can, etc.)	)-	14. Race Black, Specify:	White,	etc.	١,
2-0-	in 72 hoi "natur	Completed		15. Decedent's Edify only highest gra	ade completed)		16a. Deced (Give life. L	dent's Usual Occup kind of work done OO NOT use retire	pation during mo	ost of working		16b.	Kind of Busi	ness/Ir	ndustry	
7	with yiene.	E O	Elementary/Secon	ndary (0-12)	College (1-4or 5	i+)		lding Mar				US	Gove	rnm	ent	
2		BeC	17. Father's Name (	First, Middle, Last,	)				_	her's Name (F	irst, Middle	, Maide	n Surname,	)		
Jana	uld be Menta rked rtic er	To E	Robert M	loody					M	laggie 1	Atkin	S				
<u>8</u>	1 and 2 should be f Health and Mental em 27 is marked o ther traumatic eve		19a. Informant's Na					ig Address (Street								
≥,	and 3			Powell -	husband			Hunters								
altilliore	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev	:			Removal from State			sition (Name of natory or other plant of Cemetery)	ce)	July 24			Location - C Skippe:			9
<u> </u>	permit. Departn Imports any inju		21. Signature of Fu	meral Service Licer	isee, Sur-		22	Name and Address		J. K	. Johns	on E	uneral	Home		A.
	6				plications that caused one cause on each lin	the death. ne.	····						FD 207	20	Approxi Interval Onset a	mate Between and Death
	Physician /Medical		Immediate Cause ( disease or condition resulting in death)	Final n	a. <u>Malio</u> Due to (or as			of Kidney	7							
	Examiner	<b>.</b>	Sequentially list cor	nditions,	b											
	outed id ansit	Examiner	Sequentially list cor if any, leading to import cause. Enter Under Cause (Disease or that initiated events	mediate rlying injury	Due to (or as	a conseque	nce of):									
0/00,	rificate be executed 19 physician and as the burial-transit		that initiated events resulting in death) L	_ast	Due to (or as	a conseque	nce of):									
00	ificate g phy: is the	edical			d											
O. DOX	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 4 9 ☐ Unknown	months?	23c. If yes, outcome 1  Live birth 4  Pregnant a 9  Unknown	2 Fetal d	leath 3	Ectopic pregnand Other (specify)	су				23d. Date Mon		very Day	Year
<u>,</u>	res that ti igned by be detad	þ	Part II. Other signif	icant conditions	contributing to death b	ut not resulti	ing in the ur	nderlying cause gl	ven in Par	t I.			use contrib			of death?
ecords,	iw requii s been s s should	Completed									24a. Was	an	24b. W	ere aut	opsy findii	ngs available
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<u> </u>	sician certifi rector	Be	25. Was case referrexaminer?		Hospital:			_ Ott	oor:	ce of Death (						
5	Phys r this ral dii	<u>ان</u>	1 ☐ Yes 2 🔀 27. Manner of Death		1 lnpatie		R/Outpatier 8b. Time of	IL 3 LI DOA	4 🗆	Nursing Home			6 ☐Other		ify)	
	ending sath. or: Afte he fune	ation	1 <b>X</b> Natural 2 ☐ Accident	5 ☐ Pending investigation		y, Year)	Injury	Wor	rk? ]Yes 2[				,			
	al or Attus safter de l Directo d in by t	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	28e. Place of Inju	ury - At hom c. <i>(Specify)</i>	e, farm, str	eet, factory, office		281	f. Location City or To	(Street wn, Sta	and Number ite)	r or Rui	ral Route l	Number,
	Hospita 24 hours Funera etely fille	Medical C	29a. Certifier (Check only one)		nysician: To the best miner: On the basis o and manner sta	of examination										se(s)
	To the vithin To the Compi	Me	29b. Signature and	title of certification	Dame			29c. Licens				29d. [	Date signed	(Month	, Day, Yea	ır)
)	6		30. Name and addr	ess of porson will	oppleted cause of d	leath (Itam 5	23a) /Time			102		01	-1	7-c	201	D
	2/	þ	Ivan Zam	DC	9200	Basi		Ste ;	200	Lan	96 N	11)	20	77	4	
	Sta Registr		31. Date filed (Mont	th, Day, Year)	32. Registr	ar's Signatu	re	, , ,	,		<i></i>				·	
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			1 - For State Registrar	State of Ma	ryland / [		ent of Heal ate of Dea			giene Reg. No. 20	10	23888	5
	Physici									Day	Year 2010	3. Time of Death 7:14A ^M	1
F.	/Medic		45 City Town or Location of Death								y of Death		-
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	Funeral			Sex 7. Age XXM 2□ F	(In yrs. last bir	Yrs. If Uni		Inder 24 Hrs. ours Min.	8. Date of Birt (Month, Day	y, Year)	9. Birthpl Coun	ace (State or Foreigr try)	n
	Director		215-26-2590 Usual Residence of Decedent		90	113.			1/16/	1920	Robe	erts, MD	
	land		10a. State 10b. County		10c. City, Tow	n or Location					11	Od. Inside City Limits	;
	Mary - sh	to	MD Kent		Ches	terto	wn					1 ☐ Yes 2 No	)
	r 28a	lrec	10e. Street and Number			10f.	Zip Code		11	10g. Citizen of	What Coun	try?	
	h witi	D B	107 Southgate	Drive			21620	n		USA			
"	be filed within 72 hours after death with the Maryland that Hygiene.  do other than "natural", or items 23s or 28s-f show event, the Medical Exacting transities indiffied at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent II Armed Forces? 12 Yes 2 N			cedent of Hispan pecify Cuban, Me	iic Origin? (Spe exican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bla	ce - Americ ick, White, o		
21215-0036	hours a	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates:			2 No Sp	ecify:	1	Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Specia	MIII		
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yla	ould Men Marke	T _o	Layton Wesley						Holde				_
Mar	i 2 sh h and 7 is m fraum		19a. tnformant's Name/Relationship	. ,			ess (Street and N						
	s 1 and 2 should of Health and Men item 27 is marke other traumatic		Phillip R. Ru 20a. Method of Disposition	ssum/son_	20b. Place of	f Disposition (/	lame of	Drive	, Ches	20c. Location	VD . M - City or To	ID 21620 wn, State	_
10	Pages nent of I ant: If its ary or o		Magurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			ry, crematory o		716	12010	CI I			
Baltimore,		`	21. Signature of Funeral Service Lice		Chest		netery and Address of		/2010	Chest	ertow	n, MD	
Ba	permit. Departr Imports eny inje		DANIELS & HUTCHISON FUNERAL HOME LLC 212 N. Broad Street, Middletown DE Approximate Interval Between Onset and Death Onset and Death										
	2		23a. Part1. Enter the disease, a con	mplications that caused	the death. Do	not enter the n	ode of dying, su	ch as cardiac o	or respiratory ar	rest,	SEOWI	Approximate Interval Between	
	Physician	ĥ	Immediate Cause (Final disease or condition	ALL	· mole	the C	ier di ovo	acul cue	Direr	.0		Onset and Death	
	/Medical		resulting in death)	Due to (or as	a consequence		secon cro.	see un.	0-200			, ,	_
Ŀ	Examiner		Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
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	cate be executed physician and the burial-transit	xam	that initiated events resulting in death) Last	c	a consequence	of):							
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Box (	death certifica attending ph d for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy					23d. D	ate of delive	ry	
ă	death a atte	Iclai	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at		i 3∐Ectopio 5 ☐ Other	spregnancy (specify)			м	lonth	Day Year	
P.O.	that the de ed by the detached	hys	9 Unknown	9□ Unknown									
Vital Records, F	Se Ge	by	Part II. Other significant conditions  Penal Fail	contributing to death be	ut not resulting i	n the underlyin	g cause given in	Part I.				ie cause of death? ably 4 ∐Unknown	ח
50	v requir been si should	lete	Do Li						24a. Was	an 24b	Were auto	psy findings available	e
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tal	sician: Th certificate rector, pag	Be C	25. Was case referred to medical				26	Place of Death	1 ☐ Yes	2 12-No	T Tes	2 LI NO	_
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J Of	ding Phy h. After thi funeral o		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injui (Month, Da)	y 28b.				28d. Describe l	now injury occu	w injury occurred		
<u>Si</u>	endir sath. or: Af he fu	atlc	2 ☐ Accident investigati	on		М	1 🗆 Yes	2 🗆 No					
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Inju	ury - At home, fa c. <i>(Specify)</i>	arm, street, fac	tory, office		28f. Location (S City or Tox		ber or Rura	l Route Number,	
	pital ours a eral E	Ce	29a. Certifier 1 Certifying F	Physicien: To the best	of my knowledge	e death occur	ad at the time d	ate and place	and due to the	cause(s) and ~	nanner ac el	ated	_
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical		iminer: On the basis of and manner sta	examination ar								
	omple	Me	29b. Signature and title of certifier				29c. License nur	mber		29d. Date sign	ed (Month,	Day, Year)	
			) Such	Rom mo	7		Do0 170	036		7/11	10		
	5	+1	30. Name and address of person who	completed cause of d	eath (Item 23a)	(Type, Print)							_
			Susin Ki Ross	, m.O. 516 6	Vashing for	Are.	Elista to	on Md.	2162	0			
6	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	s Signature	A 4	n dal						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Rose Homer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany WMHS-RMC Cumberland If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** ^{Year)} 5 1928 (Month, Day, Ye Jan 15 1 🗆 M 2 🗆 F Months Days **Director** 172-30-2533 82 MD Usual Residence of Dece permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Bedford Bedford 1 🗌 Yes 2 🖳 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1024 Park Road 15522 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc py 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify. Completed 3 Divorced 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) aborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ G. Sherman Rose Nellie Deremer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 1024 Park Road PA 15522 Alma H. Rose Bedford 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State Union Cemetery 7/20/201b 4 Donation 5 Other (Specify) Bedford PA 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Sprvice Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Por 1. Enter the list asc., complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, Completed 1 Yes 2 No 3 Probably 4 Onknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 2 1 🗌 Yes 1 Impatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar VIKRAMADITYA POONAI

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

sarre

924 SETON

mo.

32. Registrar's Signature

CLUMPFPLAND, MD

10-05361 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Arnold Stephen Rosario 23888 2010 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Physician/ July 18, 2010 0930 hrs Medical Examiner Arnold Stephen Rosario 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Scotland St. Mary's 49534 Cornfield Harbour Road If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Min Hours Director 10/04/1963 217-76-3313 1 X M 2 F 46 Washington Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 1 Yes 2 X No 28a-f show Silver Spring tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once. Maryland Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 U.S.A. 2848 Aquarius Avenue ह 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status Funer If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married 2 X No Yes 1 Yes 2 X No specify: 4 Divorced If Yes, Give Year Specify. Asian þ 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Med Star Health Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within 72 and Mental Hygiene. Director of Animal Research Research Institute Facilities 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) it. Pages I and 2 should be filed riment of Health and Mental Hyl ortant: If item 27 is marked of y or other traumatic event, the Be Carol Jean Young Arnulfo Sison Rosario 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Baltimore, MD Carol A. Crabtree - Spouse 2848 Aquarius Avenue, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltemorethechematory 1 Burial 2 X Cremation 3 Removal from State 07/22/2010 Baltimore, Maryland at Loudon Park 4 Ponation 5 Other Specify. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc 21. Si ature of Funera Service Licensee MU0709 11800 New Hampshire Ave., Silver Spring, racel Approximate Interval Between Onset and Part 1. Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List one cause on each line /Medical Drowning complicating Ketamine Use Exposure Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transi per me g906 8-10-10 vt Physician/Medical 7 per fg, 3a per me x AMENDED W UNPENDED . Box 68760, he death certificate be es IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Dav Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) isigned by the atterd be detached for v 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I P.O. Š 1 Yes 2 No 3 Probably 4 V Unknown Completed funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) e Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Division of Vital Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 🗸 Other: Scene DOA 1 🗸 Yes 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury Natural 1 Yes 2 X No Pending 7-18-10 9:30 am unknown Funeral Director: stely filled in by the Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 49534 Cornfield Harbor Scotland, St. Mary's Co., Md. Rd. 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be determined (Specify) in river Homicide 29a. Certifier 1 (Check only one) completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b 8 nature and title of certifier 29c. License number July 19, 2010 O.C.M.E. ratechi, 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Merlin Donaldo Recinos

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				1- For State Registrar		-			ate of De	ath				Reg. No	2.0	1 0	2000.	
Physiciar Medical Examin				Merlin Donaldo Recinos Pena  Merlin Donaldo Recinos  Month July 10							2. Date of Do Month July 10,	eath Day		r	3. Time of Death 0514 hrs			
Funeral									c. County o									
		eral	۰	Social Security Number	6. Sex	7.	Age (In yr	s. last birt		Under 1 Ye		er 24Hrs.	8 Date of I		Montgon		holace (State or	
	Direc			None 1 M 2 F 24 Yrs. Months Days Hours Min. 08-26-1985								Honduras						
	Aug.	r i		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location         10d. li										10d. Inside City Limits				
	show	Show Dice.	'n	MD Pri	nce Ge	orge		Hy	attsvi	111e							1 X Yes 2 No	
	se Maryland or 28a-f show any	0 at 0	Director	10e. Street and Number						Zip Code				10g. Ci	tizen of Wh	at Coun	try?	
	th the	notifie	i Di	2305 Tuemmler						20785				Н	ondura	s		
	MOFE, MID 21215-0036 Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Heath and Mental Hygene. Inst. If item 27 is marked other than "natural", or items 23a or 28a-f she mit. If item 27 is marked other than "natural", or items 23a or 28a-f she	tained outer than matural, or items 228 of 268-1800 event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2	Married 1	Was Decede Armed Force Yes				ecify Cuba	ın, Mexican	ı, Puerto I	Rican, etc.)	No-	14. Race - White,		can Indian, Black,	
	rs afte	miner,	ğ	3 Widowed 4 15. Decedent's Education (S	Divorced If Ye	lates:	omalotod)	146- 6	1 X Yes		o specify:			Lini	Specify: ]			
	2 hour	Exa	eted	Elementary/Secondary (0-1		College (1-4		16a. L	Decedent's Us luring most of	working life	e. DO NOT	use retire	ork done ed)	16b.	Kind of Bus	siness/Ir	ndustry	
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	re, ML 1 and 2 sl Health ar fitem 27		d	20a. Method of Disposition			201	<ul> <li>b. Place or</li> </ul>	Disposition (	Name of ce	emetery,	1194	Date		Location - 0			
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3	<b>BAITIMOFE,</b> permit. Pages I ar Department of Hee Important: If ite	injury	İ	21. Sign ture of Funeral rvi		0.0	0.0	~1	22. Name	and Addres	s of Facility	W.H	I. Baco	n F	unera	1 Hc	me, Inc.	
	o an z Physicia	_	-	23a. Part I. E. er the disease,	or complication	ons that caus	od the dea	S /	3447	14th	St.	N.W.	Washi	ingt	on DC	200	10 Approximate Interval	
	/Medic Examin	cal		failur List only one cau immediate Cause (Final disea	se on each lin se a. Mult	_{ie.} tiple Sharp	Force	Injuries	one ne ne	ac or aying	, 3001 83 0	ar diac or	respiratory a	11651, 311	lock, of fleat		Between Onset and Death	
				or condition resulting in death	Due t	o (or as a cor	nsequence	e of):								l)		
			je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		o (or as a cor	nsequence	of):										
			Examiner	(Disease or injury that initiated events resulting in death) Las	C.	o (or as a cor	nsequence	of):										
	cuted				d											}		
_	cate be execut physician and	burial - transi	/Medical	UNPENDED	X AM	ENDED#1p	erME	<b>,</b> G906	,8/27/	2010,	WS							
9761	o / oU, ifficate be 18 physic	the state	M/U	IF FEMALE: 23b. Was decedent pregnant in	23	c. If yes, outo	ome of pre	egnancy	Fetal dea			pregnan	icv	23	d. Date of d		ay Year	
99 200	oth cert	for use as	Physician	past 12 months?	4		at time of	death 5	Other (S		Lotopio	pregnan			WOTET	Da	iy i cai	
	t the dear	8		Part II. Other significant cond	nknown 9	Unknown	ath but not	traculting	in the underly	ina souss	nivon in Da	-d-1	22a Did	labassa	contails		ne cause of death?	
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5	requir been s	should b	Completed										24a. Was				ppsy findings available	
9	ne law te has	page 2 sl	틹										auto perfe 1 <b>V</b> Yes	ormed?	de	ath?	mpletion of cause of	
0	certificate		장 음	25. Was case referred to media						26.Place	of Death (	Check or		2 N	1 1	<b>✓</b> Yes	2 No	
<del>1</del>	hysici this o	÷	ျှ	examiner? 1 ✓ Yes 2 No	Hospita	al: 1 Inpa	tient 2	ER/Out	patient 3	DOA	Other ₄	Nursing	Home 5	Reside	ence 6 🗸	Other:	Scene	
Division of Wital Bosonds	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and	funer			nding	8a. Date of Ir FOUND: Jul 10, 2010	(Year)	28b. Ti FOUN 0513			ry at Work? Yes 2 ✔	ls.	28d. Describe Subject sta			1		
	To the Hospital or Attend within 24 hours after death To the Funeral Director:	filled in by	ertification:	Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide Homicide Investigation 3 Suicide 6 Could not be determined (Specify) grounds of apt. Complex 28f. Location (Street and Number or Rural Route Nor Town, State) 1001 Quebec Terrace, Silver Spring, MD														
	Hosp 24 ho	etely f	原	29a. Certifier 1 Certifying	Physician: T													
	To the Within To the	completely	ᇷᆫ			ne basis of ex manner state	amination	and/or in				curred at	the time, date					
	3		2	29b. Signature and title of certi	ier ,	1/2	20		1	29c. Licens O.C.I						h, Day, Year)		
			-	30. Name and address of person	Desall	efed cause of	death (the	m 23a\			IVI. □.			July	/ 10, 2010			
	al st	1		Melissa Brassell, MD		ant Medica		,	111 Penn	Street, B	altimore	, MD 2	1201					
	~ / V	Sta	-	31. Date filed (Month, Day, Yea		32. Regist	arks Signa	itue	. /									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23890 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ W. /1835AM Hubert Rogers 2010 ULL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Lanham Doctor's Community Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Jan. 25, Year) 935 North Carolina Director 243-46-4337 75 Usual Residence of Decedent or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director Capitol Heights 1 X Yes 2 ☐ No Prince George's Maryland 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 20743 United States 419 Quarry Avenue Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?
1 

Yes 2 □ No Black, White, etc. þ 1 Never Married 2 X Married Black 1 ☐ Yes 2 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Guidance Counselor Government Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Luther Rogers Martha Stallings 19a. Informant's Name/Relationship (Type, Print)
Thelma Rogers/ Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 419 Quarry Avenue Capitol Heights, Md. 20743 Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Gethsemane Missionary Bapt. Church Cemetery 1 Burial 2 Cremation 3 Removal from State 18, ☐ Donation 5 ☐ Other (Specify) Bunn, North Carolina re of Funeral Sovice 22. Name and Address of Facility Stewart Funeral Home, 21. Sigi Inc. 4001 Benning Road NE Washington, DC 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ METASTATIC COLON CANCER disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner METASTASIS PULMONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed METASTASIS Cause (Disease or iinjury LIVER been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical PNEUMONIA ATYPICAL Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has page 2 s autopsy performed? Yes 2 After this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \) Nursing Home 5 \( \) Residence 6 \( \) Other (Specify) 1 ☐ Yes 2 X No မ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1X Natural injury 5 Pending Accident
Suicide Investigation Director; / 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined hin 24 hours af the Funeral Di mpleted filled ir Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I

comple only one)

State Registrar

10

the

31. Date filed (Month, Day, Year) **JUL 1 9 2010** 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MELVIN W. GASKINS

Kuro, MP

MD

7831

BELLIE

29c. License number

D43162

29d. Date signed (Month, Day, Year) 7/13/10

POINT DL. GLEENBELT, MD 20776

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Michelle Ann Staubs Medical 4c. County of Death Facility Name (if not institution, give street and number City, Town, or Location of Death Examiner picl AT lisburl 7. Age (In yrs. last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🖾 F Months Hours Min. 43 213-92-6705 **Director** Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic avent, the Medical Examiner must be notified at once. Director MD Worcester Berlin 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21811 USA 11003-14 Grays Corner Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after al Hygiene. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 XDivorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Betty M. Shiflett <u> Earl T. Majors</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) taubj 11003-14 Grays Corner Rd., Berlin, MD 21811 Betty Majors / mother 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Carcemation 3 Removal from State 4 Donation 5 Other (Specify) 7/16/2010 Frankford, DE Cape Henlopen Crem. 21. Signature of Funeral § rice Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the ens Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician MRTASTA OVARIAN disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine If any leading to immedit cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 Yes 2 HNO 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) & ENO Hospital Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: A ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie D0057410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (a Haus 2/802 WAT 300 Date filed (Month gistrar's Signature State 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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white

MD

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

HOSPICA

1 🗆 Yes 2 🔽 No

DHMH 17 Rev 7/2009

Registrar

Physicia /Medic Examin

Funeral Director

	1 - State State Registrar		tificate of L			Reg. N2 0 1	0	23892			
ın	1. Decedent's Name (First, Middle, Last) Genevieve Jones Shaw	1, Day 2010	Year	3. Time of Death 11:40 PM							
al er	4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County o					
	5. Social Security Number 6. Sex 7. Age (In	Heritage Harbour Rehabilatation Ctr Annapolis Anne Ar 5. Social Security Number 214-05-1930 $\stackrel{6. \text{ Sex}}{}^{1 \square \text{ M}} \stackrel{7. \text{ Age } (ln \text{ yrs. last birthday)}}{}^{7. \text{ Age } (ln \text{ yrs. last birthday)}} \stackrel{\text{If Under 1 Year}}{}^{\text{Months}} \stackrel{\text{If Under 24 Hrs.}}{}^{\text{Months}} \stackrel{\text{8. Date of Birth}}{}^{\text{Month, Day, Year}} \stackrel{\text{9. Birth}}{}^{\text{Month, Day, Year}} \stackrel{\text{9. Birth}}{}^{\text{Month}} \stackrel{\text{Months}}{}^{\text{Days}} \stackrel{\text{If Under 1 Year}}{}^{\text{Month}} \stackrel{\text{If Under 24 Hrs.}}{}^{\text{Month}} \stackrel{\text{8. Date of Birth}}{}^{\text{Month}} \stackrel{\text{Month}}{}^{\text{Days}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{\text{Month}} \stackrel{\text{North}}{}^{Mo$									
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ŗ	10a. State 10b. County 10c. Maryland Anne Arundel		10d. Inside City Limits 1								
Be Completed by Funeral Director	10e. Street and Number	hat Cou									
	301 Glen Avenue	Amari	USA								
	11. Marital Status  1 Never Married 2 Married Armed Forces?  1 Yes 2 Mroll Fres, Give Year or Dates:	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No If Yes, Give 1 ☐ Yes 2 і No Specify: Specify: W									
ompleted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give k	ent's Usual Occupi ind of work done o O NOT use retired 1 Servic	during most of work f)	ting	US Gov		•			
Be C	17. Father's Name (First, Middle, Last)		T PELATC		e (First, Middle,	Maiden Surname	-	ineri c			
၉	Edward Jones  19a. Informant's Name/Relationship (Type. Print)	19b Mailing	Address (Street	Ida Nand Number or Ru	layhew	er City or Town S	State. Zi	in Code)			
	Mary Cummings - Sister	2614	Rigging	Dr, Anna		MD 21401					
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	lis	own, State , MD								
	21. Signature of Funeral Service Licenses  Muglin , Wilden			of Glouce				al Home , MD 21401			
Examiner	23a. Part 1. Enter the disease, or complications that caused the cansock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a condition or cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a condition or cause. Enter Underlying Cause) Due to (or as a condition or cause. Enter Underlying Cause) Due to (or as a condition or cause. Enter Underlying Cause) Due to (or as a condition or cause. Enter Underlying Cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or as a condition or cause) Due to (or		Approximate Interval Between Onset and Death (G Weevs)								
Completed by Physician/Medical Examiner	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ Yo 9 ☐ Unknown  23c. If yes, outcome of prediction of the pregnant at time in the past 12 months?  9 ☐ Unknown		Date of delivery Month Day Year								
l by P	Part II. Other significant conditions contributing to death but not	t resulting in the und	derlying cause give	en in Part I.	23e. Did to			the cause of death?			
Completed		ere autrior to co	copsy findings available ompletion of cause of								
Be	25. Was case referred to medical examiner?  1  Yes 2 No										
ion: T	27. Manner of Death 1 ★Natural 5 Pending 28a. Date of Injury (Month, Day, Yea		Describe how injury occurred								
Medical Certification: To	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Sp.	At home, farm, streed oecify)		M 1 □ Yes 2 □ No , factory, office 28f. Location (Str City or Town				Street and Number or Rural Route Number, vn, State)			
dical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
Mec	one) and manner stated.  29b. Signature and title of certifier	(Month	, Day, Year)								
	20 Name and address of access who access that	- /	2010								
	30. Name and address of person who completed cause of death Stravt E. Scionick, W	10 900	Besta	ate Ra.	Anna	polis, V	nd	. 21401			
e ar	31. Date filed (Month, Day, Year)  JUL 13 2010  32. Registrar's S	signature .	arke								

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death cedent's Name (First, Middle, Last) 2. Date of Death Month 2010 4a. Facility Name (If not institution, give street and number, 4c. County of Death er 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Numbe . Age (In yrs. last birthday, Months Min. Hours Days 1 X M 2 □ F 091-32-1087 9/18/1937 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No MD Kent Rock Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6002 Lawton Avenue 21661 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Never Married 2X Married 1 □Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Santangelo Viola Cardone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Santangelo/ Wife 6002 Lawton Ave, Rock Hall, MD 21661 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Chesapeake Cremation: 7/16/10 Stevensville, MD 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 21. Signature of Funeral Service License Krik 9 130 Speer Rd. Chestertown, MD 21620 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final CHRONIC OBSTRUCTIVE PULMONARY disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OBSTRUCTIVE SLEEP APNEA 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No METABOLIC ENCEPHALOPATHY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury (Month, Day, Year) 5 Pendina

**Physician** /Medical Examiner

permit. Page:
Deportment of
Important: If
any injury or

**Physician** 

/Medical

**Examiner** 

Director

Funeral

2

Completed

B

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**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it is Medical Evantical must be notified at

Baltimore, Maryland 21215-0036

Examiner Physician/Medical

attending physician and for use as the burial-trar signed by the a page 2 should peen has certificate

2

Completed

Be

Certification: To

Medical

(Check only one)

law requires that the death certificate be executed

P.O. Box 68760,

of Vital Records,

Division or Attending

funeral director, After To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After the Funeral Director with the fur

State

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death Natural 2 Accident investigation 1 ☐Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D0041587 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

Speer Rd. Chestertown, MD 21620 Helen 31. Date filed (Month, Day Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Physician/ 3. 2010 7:50 P M Virginia Ann Porter Startt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Queen Anne's 609 Fourth Street Crumpton Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2**X** F Hours Min. 1/31/1938 Director MD 216-38-0553 Usual Residence of Decedent items 23a or 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No MD Queen Anne's Crumpton 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral USA 21628 609 Fourth Street 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Completed by Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 3 ★ Widowed 4 □ Divorced Year or Dates and Mental Hygiene.
is marked other than "natural" aumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Caregiver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည William Maynard Porter, Sr. permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic Clara Musser Rollison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 130, Crumpton, MD 21628 Carol A. Cox/ Sister 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 7/6/2010 Stevensville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 30 Speer Rd. Chestertown, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final Ph sician/ MNC EATIC disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examin attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 1 ☐ Live Birth 2 ☐ retail 4 ☐ Pregnant at time of death in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year signed by the a d be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 💢 Probably 4 ☐ Unknown 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Jas autopsy page death? 2 No 1 🗌 Yes Yes 25. Was case referred to medical completed filled in by the funeral director. Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

Division of Vital Records, P.O. Box 68760

After this certificate 24 hours after death. Funeral Director: A

within 2 To the

Registrar

Certificate:

Medical

5 Pending

Investigation

determined

6 Could not be

27. Manner of Death

Natural

4 Homicide

only one) 29b. Signaturi

29a. Certifier (Check

Accident

Suicide

gistrar's Signature

28a. Date of injury (Month, Day, Year)

hestertown MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my orbital death.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at

1 🗌 Yes 2 🗆 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d, Date signed (Month, Dav. Year)

28f. Location (Street and Number or Rural Route Number,

28d. Describe how injury occurred

City or Town, State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier [ 23895 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav **Physician** Month LaVerne Magdalene Stump 2010 1:50 P July 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Devlin Manor Health Care Center Cumberland Allegany If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 02/20/1922 9. Birthplece (State or Foreign **Funeral** Months Days 1 ☐ M 2 🂢 F Hours 88 215-20-6088 Maryland Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Itam 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the <u>Neulcal Examiner must be notified at</u> 17 Yes 2 □ No Director Allegany Cumberland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 235 Paca Street, Apt 705 USA 21502 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after ☐Yes 2☐No 1 Never Married 2 Married þ Yes Give 1 ☐ Yes 2 ☐ No Specify Specify: White 3 ₩idowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Elevator Operator Retail filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) es 1 and 2 should be fill of Health and Mental H Be Virgie Ellen Roland Harrison Greenawalt William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Itam 27 Is rr any injury or other traurr 900.8. 1016 Chestnut Ridge Road, Morgantown, WV Linda Stump / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/14/2010 Cumberland, MD Hillcrest Mem. Park 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service/Lice 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** mounte /Medical resulting in death) we to (or a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner transil. death certificate be executed and Due to (or as a consequence of): as the burialed by the attending physician detached for use as the buria Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2□ No 2 No 1 Yes Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 🔯 Nursing Home 5 🗌 Residence 6 🗍 Other (Specify) 2 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attand within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0054411 July 12, 2010

State Registrar 31. Date filed (Month, Day, Year) JUL 12 2010

30. Name and address of

Beverly Calkins, M.D., 600 Memorial 32. Registrar's Signature

rson who completed cause of death (Item 23a) - e. Print)

Maryland 21215-0036

Baltimore,

68760.

Box (

P.O.

Records.

Division of Vital

21502

Avenue, Cumberland, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23896 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Linda Lee Swanger Monthuly 9 2010 ear 12:10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WMHS - REGIONAL MEDICAL CENTER ALLEGANY CUMBERLAND If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours (Month, Day, Year) Director 216-62-1475 56 Marvĺand 07/10/1953 Usual Residence of Decedent or 28a-f show 10a. State "natural", or items 23a or 28a-f sho 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with: Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must ba Funeral 122 Memorial Avenue, Apt 13F 21502 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify 3 Widowed 4 Divorced Completed White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Hospital Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas Eldon Bennett Violet Rosetta Hendershot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randall D. Swanger / Husband 108 Dogwood Drive, Ridgeley, WV 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) MD Vet Cem @ Rocky Gap 07/15/2010 Flintstone, MD 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia Menningetin Physician Stre disease or condition Medical resulting in death) Due to (o as a consequence of): **Examiner** 240. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner signed by the attending physician and I be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Connective + 1850 1 Yes 2 No 3 Probably 4 Nown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No No No Yes 1 🗌 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? <u>1</u>2 2X No Other: 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director; After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5  $\square$  Pending 1 Tyes 2 🗌 No Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🕢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. See thym Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ファム State Registrar

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625 KENT AVENUE, HUMA, M.D., SHAKIL Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

only one)

29b. Signature and title of certifie

D46346

29d. Date signed (Month, Day, Year)

10/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23897 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Beverly D. Shaw 2010 7. 2:57p July 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death 9727 Mt. Pisgah Road, #103 Silver Spring Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 15, 6. Sex 9. Birthplace (State or Foreign Days 1 🗆 M 2 🖵 F Months Hours 067-60-2580 New York 48 1961 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 9727 Mt. Pisgah Road, #103 20904 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 XYes 2 No Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XNo Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates. 1979-83 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Florist Floral Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leroy Somers Willie Mai Franklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Shaw/Husband 104 Brenda Drive, Jacksonville, NC 28546 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July15, 2010 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, otheart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) Cardiorespiratory Arrest Due to (or as a consequence of): Cerebrovascular Accident Due to for as a consequence of Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Systemic Lupus Erythematosus 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 - Fetal death in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year

Pnysician/ Medical Examiner

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Certificate:

Medical

29b. Signature and title

30. Name and ad

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MD

death certificate be executed

law requires that the

Records, P.O. Box 68760

**Division of Vital** Hospital or Attending Physician: Physician/

Medical

**Examiner** 

**Funeral** 

Director

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ral", or items 23a or Examiner must be I death with

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should be file I and Mental Fish marked of

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permit. Page 1 Department of Important: If it any injury or o

the Medical

Saltimore, Maryland 21215-0036

Director

Funeral

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Completed

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Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant

Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Chronic Renal Failure, Stage VI 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hypertension autopsy performed? 1 ☐ Yes 2 🔀 No death? Renal Osteodystrophy 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 XNo Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗓 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined *Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D47867

29d. Date signed (Month, Day, Year) July 15, 2010 July 15,

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31. Date filed (Month, Day, Year) Registrar

4701 Randolph Road, #216, Rockville, MD 20852

n who completed cause of death (Item 23a) (Type, Print)

Pregnant at time of death

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 07-13-2010 Year **Physician** 6:00 PM Martha Lee Smith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Thomas More Medical Comp. Hvattsville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Hours 1 □ M 2 🛣 F 11-6-1936 Director 578-44-4868 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be recitled at 1√∑Yes 2 □ No Director Prince George's Oxon Hill 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20745 USA 7103 Livingston Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify 2 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)  $5\,t\,h$ College (1-4or 5+) Private Industry Nursing Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lula Jones General McArthur Garrett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7103 Livingston Rd., Oxon Hill, MD 20745 Diane Pierrelus/daughter If item 27 or other t Baltimore, 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important; If iter
any Injury or oth 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 07-19-2010 Riverdale, MD Riverdale Crem. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Şervice Licensee 22. Name and Address of Facility 20746 Mary Hedgman MO1374 Cedar Hill FH,4111 PA Ave., Suitland, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): hysician 12018 /Medical Examiner Sequentially list conditions, if any, leading to firm ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sue to for early ronsequence of Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical the as IF FEMALE for use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? . ∟Yes 2 No 9 □ Unknown Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has b completely filled in by the funeral director, page 2 st autopsy 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29d. Date signed (Month, Day, Year) 296 License number 29b. Signature and title of certifier d 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) beenslowing Rel Hyatton 14 MD 2070) Paul DEVORE 32. Registrar's Signature 31. Date filed (Month, Day, State sacke Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23899 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>010</u> Physician/  $J_{ulv}^{\text{Month}}$ Dorothy Mae Sheckells 12 9:40 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😾 F 9713/1926 83 Maryland Director 217-40-8975 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at should be filed within 72 hours after death with the Maryland n and Mental Hygiene. r is marked other than "natural", or items 23a or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Tracy's Landing 1 Yes 2 No Maryland Anne Arundel 10g. Citizen of What Country? 20779 Funeral 5860 Old Solomons Island Rd. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) U.S. Postal Service Postmaster Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Viola Arminger James Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau 825 Childs Point Rd., Annapolis, MD 21401 Joyce A. Phipps/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. James' Cemetery 7/17/10 Lothian, MD 21. Signatur 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ UYUT1AM Concer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown cate has been siç ; page 2 should b 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 Yes 2 No After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director, After I (Month, Day, Year) 1 Natural 5 Pending work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature ar title of cet 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

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ason

31. Date filed (Month, Ma

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pagistrar's Signature

1. Le 300

Please Type or Print in Black Indelible Ink, 5 psure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

noy comuna		1- For State Registrar	Of Maryland / L	Certificate of		nu Mentar		2011 eg. No.	23900
Physicia Medical Examin		1. Decedent's Name (First, Middle,La					2. Date of Dea Month	ath Dav Year	3. Time of Death 0530 hrs
INCUICAI EXAIIII	liei	Roy Linwood Sewa 4a. Facility Name (if not institution, gi		4	b. City, Town, o	or Location of De	July 12, 2	4c. County of Dea	
		Rt. 304 & Safety Drive			Centerville			Queen Anne	
Funeral Director		Social Security Number     6, S		n yrs. last birthday)	If Under 1 Ye		Hrs. 8. Date of Bir Min.	rth(MM/DD/YYYY) 9. B Fore	ian
Director		219-46-2539	M 2 F	61 Yrs.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		9, 1948 °	ountry)Maryland
gus		10a, State 10b. County	100	c. City, Town or Location	on		- H		10d. Inside City Limits
and f show	ō	Maryland Carolin	ie	Goldsboro					1 Yes 2 No
Maryl r 28a-	Director	10e, Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
ith the	al D	211 O1d Town Roa	d 12. Was Decedent Eve	arin IIS 13 Was	2163		( Specify Yes or No	U.S.A.	rican Indian, Black,
leath w	Funeral	1 Never Married 2 Married		If Ye	s, specify Cuba	an, Mexican, Pue	erto Rican, etc.)	White, etc.	rican indian, black,
after (ral", o	ΡĀ		If Yes, Give Year or Dates:	1	Yes 2X N			Specify: Wh	
2 hours	ted	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	nly highest grade comple College (1-4 or 5+)			ation (Give kind of e. DO NOT use r		16b. Kind of Business	/Industry
036 thin 72 ne.	Completed	12	conege (1-4 of 5.)	Mosquit	o Ahate	ment Pr	ooram	Queen Anne	's County
15-0 illed will Hygie d other		17. Father's Name (First, Middle, Last		prosqui	215000		me (First, Middle, M	Maiden Surname)	3 Oddie y
2121 ald be f Mental marke	o Be	Linwood Herman Se 19a. Informant's Name/Relationship (		19b Mailing	Address /Stre		Anne Bell	L nber, City or Town, Stat	a Zin Codo)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.		Nancy Seward/spou		*					21636
s l and of Health		20a. Method of Disposition  1 X Burial 2 Cremation 3	Removal from State	20b. Place of Disposit crematory or other	ion (Name of ce		Date	20c. Location - City o	
imo Page ment c		4 Donation 5 Other Specify		Mt. Olive	Cemeter	y Ju	1y17,2010	Felton, D	elaware
Ball permit Depart Impor		21. Significate of Funeral Service Licer	eree	22. Na F1	me and Addres	ss of Facility nd Helf	enbein Fu	ienral Home isboro, Mar	, PA
Physician		23a. Part I. Enter the disease, or comp	olications that caused the	death. Do not enter the	mode of dying	g, such as cardia	c or respiratory arre	isboro, Mar est, shock, or heart	Approximate Interval
/M i l Examiner	ı		Multiple Injuries						Between Onset and Death
	-	or condition resulting in death)  Sequentially list conditions  b.	Due to (or as a conseque	ence of):					
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conseque	ence of):					1
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ecuted and - transi		d.							
760, cate be executed physician and he burial - transit	eg	UNPENDED	AMENDED						
3876 rtificat ing phr as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of		I death 3	Ectopic preg	jnancy	23d. Date of deliver Month	y Day <b>Y</b> ear
Sox 687/death certifica	Sici	1 Yes 2 No 9 Unknown	4 Pregnant at time 9 Unknown	of death 5 Othe	er (Specify)				
P.O. Be that the de- ned by the detached f		Part II. Other significant conditions		not resulting in the un	derlying cause	given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
S, P.( irres than signed d be det	sq pa					_	1 Yes	2 ✓ No 3 Pro	bably 4 Unknown
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tal Rec	Completed						perform 1 V Yes 2	med? death? 2 No 1 ✓ Y	es 2 No
fital Rec sician: The is certificate irector, page	Be	25. Was case referred to medical examiner?	lospital: 1 Inpatient	2 ER/Outpatient		Other Nurs		Residence 6 ✓ Othe	r. Saana
n of Vit ding Physia After this funeral dir	밝	1 <b>✓</b> Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of Inju		ury at Work?	28d. Describe h	low injury occurred	
rision r Attendii er death. irector: An by the fu	턃	1 Natural 5 Pending 2 ✓ Accident Investigati	FOUND: Jul 12, 2010	FOUND: 0530 hrs	1 🗌	Yes 2 🗸 No	and rolled ov		that left roadway
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.  The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	Certification:	3 Suicide 6 Could not	28e. Place of Injury	- At home, farm, street,	factory, office I	building, etc.	or Town, St	tate)	iral Route Number, City
Di e Hospital		29a Certifier	an: To the best of my kno	Road / Highway	d at the time d	ate and place, ar		ety Drive, Goldsboro	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	(Check only one)  2  Medical Examiner							
H S H S	ž	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mo	nth, Day, Year)
		aral H	llan		O.C.	M.E.		July 13, 2010	
		<ol> <li>Name and address of person who carol Allan, MD Assista</li> </ol>	completed cause of death nt Medical Examine		reet, Baltim	ore, MD 212	01		
Sta	te	31. Date filed (Mooth Day Yar) 201			1				
Registr	ar	JOE 8 0 201	U ACCOUNTS	THE PROPERTY.	Sandari .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 10d per DVR G906 8/9/10 dk
State of Maryland 7 Department of Health and Mental Hygiene 0 1 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month PM lav Medical 2010 TIII.Y . 15 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing Home Berlin Worcester 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 PA 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 1 M 2XXF Days Hours Months Min. Director 165-20-1467 83 07/27/926 Yrs PA Usual Residence of Deceden or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester Berlin 1 Tes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? injury or other traumatic event, the Medical Examiner must be 23a Funeral 9837 Narrow Branch Rd 21811 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 9 ģ 1 Never Married 2 Married 1 Yes 2 No Specify. White "natural", 3 → Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Customer Attendant Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Joseph Kisloski Agatha Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Tocyloski 9837 Narrow Branch Rd. Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 07/21/2010 Berlin, MD f Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on jach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 0 Due to (or as a conse Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Berandon 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year n signed by the at Id be detached fo Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 LHo Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 🗌 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident
Suicide 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical

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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

STEINER, MARION

State Registrar 29a. Certifier

(Check

only one 29b. Signature and title of certification

2 🗆

30. Name and address of person who com

31. Date filed (Month, Day, Yea

Year) 16

(Item 23a) (Type, Print)

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1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

29c. License number

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2000. 23902

		•	1 - For State Registrar	State of Maryland		tificate of D			Reg. No.		
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ıth	Year	3. Time of Death
	Medic	al	JAMES  4a. Facility Name (if not institution, give stre	E .	TU	4b. City, Town, or I		JULY 1		2010 Year County of Death	4:15 P M
	Examin	er	Glade Valley Nursin			Walkers				Frederic	k
	Funeral Director	8	213-16-0012	7. Age (In yrs. last I	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min,	8. Date of Birtl JAN • 28 •		9. Birth Mary	place (State or Foreign Tand
	Maryland 28a-f show otified at	rector	Usual Residence of Decedent  10a. State 10b. County  Maryland Frederick	10c. City, To		ation Sville					10d. Inside City Limits 1 ☐ Yes 2 🔀 No
:	with the s 23a or ; ust be n	Funeral Director	10e. Street and Number 10310 Old Annapo	lis Rd		10f. Zip Code 21793				zen of What Cour ted Stat	-
950	I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  Health and Mental Hygiene.  The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status  1  Never Married 2 M Married  3  Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ♣ Yes 2 ☐ No If Yes, Give Year or Dates. WW II		/as Decedent of His Yes, specify Cuban		cify Yes or No- Rican, etc.)		14. Race - Americ Black, White, Specify: Whi	etc.
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saitimore,	Page 1 and nent of Heal int: If item 2 iry or other		20a. Method of Disposition 1	moval from State ceme	etery, crem	ition (Name of atory or other place	)	Oate 6,2010		cation - City or To	
Palt	permit. Page 1. Department of 1. Important: If its any injury or of once.		21. Signature of Funeral Service Licensee	Pelennon	22.	Name and Address	of Facility Star	uffer F	unera	al Homes	., P.A.
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noision	al or Arce s after de al Directo ed in by th		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, office		28f. Location (S City or Tow		Number or Rura	l Route Number,
	ne nospri	Medical	(Check 2 Medical Examiner:	n: To the best of my knowledg On the basis of examination an ractioner: To the best of my kn	d/or investi	gation, in my opinior	n, death occurred at	the time, date a	nd place,	and due to the ca	use(s) and manner stated.
	Norith Coa		29b. Signature and title of certifier	of MD	ę	29c. License	number 54636		29d. Date	e signed (Month,	Day, Year) 2010
7	FIVA		30. Name and address of person who comp		a) (Type, Pi	rint)	~	denic	k. 1	Mt. 2	1701
/1	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signature		Barkel	1	,		. 4 - 1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4/38 Am Physician/ Year Month JULY ohamy 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE WASHINGTON MEDICAL CENTER GHEN HRUNDEL ANNE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 1 M 2 X F Months 9/14/195 Director 219-56-3659 58 Usual Residence of Decedent 10a. State 10b. County death with the Maryland items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No MD Anne Arundel Arno1d 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 827 Buena Vista Ave. 21012 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. Completed by 1 Never Married 2 Married 1 Yes 2XXNo If Yes, Give EL TOHAMY , ひみんしらり E Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hattie · Foard Charles H. Little 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tamer El Tohamy Buena Vista Ave. Arnold, Spouse MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/16/2010 Parkwood Cemetery Baltimore, MD 21. Signature of Funer Service License 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis. Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition days Medical resulting in death) (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Dav Year Pregnant at time of death g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by renal kilure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🕅 No Other: မ 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 30. Name and addr ss of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Month Year Illahman Vicia 945a M JULY 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Anne BUCNIE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth **Funeral** 1 🗆 M 2 🛛 F Months Hours Min. 213-28-9493 Director 79 930 Sept 04. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21146 USA 108 Berrywood Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White Completed 3 Widowed 4 Divorced Specify ilghman, Patricia 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Gill Regina Yuhn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Tilghman / husband 108 Berrywood Drive Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 16, cemetery, crematory or other place) New Cathedral Cemetery Baltimore, MD 2010 21. Signature of Fundal Service-Licensee a ranco^{Adges}Sons^{iy} P.A. 495 Ritchie Highway Severna Park Funeral Home Severna Park, MD 21146 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ esophaceal metastanc disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 ☐ Yes 2 No 1 🗆 Yes 2 🗆 No 25. Was case referred to medica Be 26. Place of Death (Check only one) 2. No 1 Tes Other: မ 1. Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1-Natural 5 Pending work 24 hours after death. Funeral Director: A 1 🗌 Yes 2 🗌 No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, gate and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) d 00694 10am

State

Registrar

BWMC

201 Hosp Drive. Glen Burma

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

McIlmonle

3€. Registrar's Signature

Elizabeth

JUL 1 5 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dorothy M. Thomas July 13 9:08 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1414 Ray Road/Kings Jefferson House Hyattsville Prince George's Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min May 23, 577-24-7868 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's 1 X Yes 2 No Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 908 Fairoak Avenue 20783 <u>United</u> States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married **Black** If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Accountant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Melinee Thomas Joseph Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antoinette Ward/ Grand-Daughter 5310 Lacy Road Durham, NC 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 17, 4 Donation 5 Other (Specify) Lincoln Memorial Suitland, Maryland ture of Fundal Service 22. Name and Address of Facility Stewart Funeral Home, 4001 Benning Road NE Washington, DC 20019 23a. Part Enter the disease , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Dementia resulting in death) Due to (or as a consequence of): CVA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or impur Hypertension that initiated events resulting in death) Last Due to (or as a consequence of) Hypercholesterolem IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏝 Unknown 24a. Was an autopsy

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be filed within 72 hours after death with the Maryland

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permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra

injury or

Maryland 21215-0036

Baltimore,

Box 68760

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Division of Vital Records,

attending physician and for use as the burial-transit that the death certificate be executed signed by the law requires neec cate has page 2 s To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I MI, Old Were autopsy findings available prior to completion of cause of perform death? 1 Tes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Assistant Living 1 ☐ Yes 2 🛣 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending 2 Accident 3 Suicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6525 Belcrest Road Ellen D. Finkelman, M.D. Hyattsville, Md. 20782

31. Date filed (Month, Day, Year) **JUL 1 9 2010** 

32. Registrar's Si

Please Type or Print in Black Indelible Lake Engure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar WEND#5+12perFH, 7-19-10, EMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 2010 Month Ju1vHosea Eldridge Taylor Jr. 1:05 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1013 Crest Haven Drive Silver Spring, Md Montgomery County 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth Nov. 3, 1925 **Funeral** 9. Birthplace (State or Foreign Hours Min. 1 😾 M 2 🗆 F Months Michigan Director 84 376-20-8693 Usual Residence of Decedent show 10a, State death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits DC 1 K Yes 2 No <u>Washington</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1749 North Portal Drive, North West United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 be filed within 72 hours after If Yes, Give Year or Dates. WW_II 1 ☐ Yes 2 X No Specify. "natural", Specify: African American Completed 3 X Widowed 4 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 <u>Supervisory Patent Examiner</u> Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ other traumatic t. Page 1 and 2 should by thent of Health and Mer Hosea E. Taylor, Sr. Mollie Sewell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1749 North Portal Drive, N.W. Erica Tavlor/Daughter Washington, D.C. Important: If iten 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 07/14/2010 Washington, D.C. Creek Cemetery 21. Signatur of Furieral Service License 22. Name and Address of Facility McGuire Funeral Service, Inc. Þ 7400 Georgia Avenue, N.W. Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cardiopulmonary Arrest Medical Due to (or as a consequence of) Examiner Asystole Sequentially list conditions, if any, leading to immediate cause. 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Box 68760 23c. If yes, outcome of pregnancy
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1 Yes 2 No Pregnant at time of death Day Year Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Advanced Vascular Dementia, Chronic Renal Failure, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown should 24a. Was an 24b. Were autopsy findings available Hypertension page 2 s prior to completion of cause of death? autopsy performed? Yes 2X No Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 **X** No မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify Group Home 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director: Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated сопретед Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 L 3 L To the I within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer 29c, License numbe 29d, Date signed (Month, Day, Year) 9+1 D0032654 July 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Serlemitsos 2033 Penderbrooke Drive, Crownsville, Maryland 20903 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 16

Registrar

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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Ione.		4 Donation	5 Other (S)		ate Arli		Nat. Cen		0/27	/2010	Arlin	ngton,	VA
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	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completed filled in by the funeral director.	Medical	(Check 2		aminer: On the basis of lurse Practioner: To t	f examination	and/or investig	ation in my oninic	n death acc	urrod at th	a time date an	d place and	d due to the se	Landa Landananan data d
_	Verith Com	2	9b. Signature and tit	le of certifier	elle			29c. License	number	,	2	9d. Date si	igned (Month, I	Day, Year)
	10		0 Name and address				220/ (5 5 :	-	322			/ .	9.1	V
			Nooshin	Farr MI	o completed cause of 1500 Fore	est Gle	en Rd.	Silver S	SPring	, MD	20910			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23908 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Jul Michelle Turner Day 9 Sara 7:30 pM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Hospital Rockville Montgomery 2010 If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth 214-80-8862 Days Hours Min. 40 11/7/1969 Director Washington DC Usual Residence of Decedent show 10a. State oortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Montgamery Rockville 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9917 Gable Ridge Terrace Unit I 20850 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 14. Race - American Indian, Black, White, etc. <u>ک</u> 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ should be filed within and Mental Hygiene. Lawyer Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Bernard Patrick Cox Susan Michelle Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 805 N Howard St. #123 Alexandria, VA 22304 permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Bernard Patrick Cox, father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Everly Crematory 07/21/2010 Alexandria, VA 21. Signature of n Service License 22. Name and Address of Facility Everly Wheatley Funeral Home 1500 W. Braddock Rd. Alexandria, VA 22302 any Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ot Physician/ Cirr hosis disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner disease HVEV Sequentially list conditions Examine tay, leading to minimum adata cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and impleted filled in by the funeral director, page 2 should be detached for use as the burial-transit tailure that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 1 ☐ Yes 2 ☑ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) ၉ 1 🗌 Yes 2 🗶 No Other: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State within 24 hours a

To the Funeral D

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Sireesha Jalli 000 65080 7/11/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDICAL LENTER DRIVE MD 20850 ROCKVILLE

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 24a per phys. G906 8/19/10 dk State of Maryland / Department of Health and Mental Hygiene Amended # 11 - State Registrar 23909 7/2/10, T.M. Kent Co. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)
NEEDLES
ANNETTE NEEDLES USILTON 2. Date of Death 3. Time of Death Physician/ **30**^{Day} JUNE. 2010 12:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death HOSPICE CENTER OF QUEEN ANNE'S CENTREVILLE QUEEN ANNE'S 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours AUG**, Pearl 934 214-30-7726 Director MD Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shouy or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits Director DE SUSSEX **MILLSBORO** 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 204 MAGNOLIA DRIVE 19966 **USA** 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 3 **X** Widowed 4 □ Divorced Completed Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 SECRETARY **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HORACE NEEDLES FRANCES BACON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CINDY LEE USILTON/DAUGHTER 204 MAGNOLIA DR., MILLSBORO, DE19966 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) CHESTERFIELD CEM. 7/2/2010 CENTREVILLE, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME
130 SPEER RD. CHESTERTOWN, MD 21620 . Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CANCER Medical Due to ( r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on signed by the attending physician and I be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 Yes 2 No Yes 2x No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? HOSPICE CENTER 1 🗌 Yes 2 1 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work? 2 Accident
3 Suicide
4 Homicide 1 Tes 2 🗌 No Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature and title of certified 29c. License number 29d. Datę signed (Month, Day, Year) 3 30 2010 ne and address of person who completed cause of death (Item 23a) (Type, Print) JUKENS me ille ROAD Im ( p. 21617 2540 Correntle m 31. Date filed (Month, Date) State 32. Regi

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 20<u>10</u>  $J_{uly}^{\text{Month}}$ Physician/ 13 9:15 A Gerard Daniel VanDagna Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Riva 3130 Stonehenge Drive 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** New York Min. (Month, Day, Year) 2/26/1949 Months 130-38-7039 61 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyliene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Tes 2 No Riva Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3130 Stonehenge Drive 21140 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Information Systems Sales 3 years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Frank VanDagna Bertha Krause 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3130 Stonehenge Drive, Riva, Maryland 21140 Victoria VanDagna/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Cemetery 7/20/10 Davidsonville, MD 22. Name and Address of Facility George P. Kalas Funeral Home Licensee 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Exam Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birtin 2 Live of death
4 Pregnant at time of death
9 Unknown Day in the past 12 months? Month Year 1 Yes 2 No been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 2 000 ☐ Yes 2 1 Yes certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 2 |은 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work Natural 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Dale signed Month, Day, Year) 29b. Sig title of certific ۵ 20

Registrar

State

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Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		e/Relationship (Type, Pri					umber, City or Town, State	e, Zip Code)
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Baltimore, permit. Pages 1 ar Department of Her Important: If ite		Cremation 3 Rem		natory or other p	(Name of cemetery, ace)	Date	20c. Location - City of	Town, State
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_	30. Name and address	of person who complete	d cause of death (Item 23a				<u> </u>	
	Ling Li, MD	Assistant Medical	Examiner 111 Pe	nn Street, Ba	Iltimore, MD 2120	)1		
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	/Medic Examir		4a. Facility Name (If not institution, give					r Location of De		40	County of Dea	
П	CXamii	iei			die 1		0	1	land			youry
	Funeval		5. Social Security Number 6. S	Regional Me			der 1 Year	If Under 24 H		irth		thplace (State or Foreign
	Funeral Director			<b>Z</b> -M 2□ F		Yrs. Month		Hours Mi				naryland
			Usual Residence of Decedent						0101	1 3/1		TOT VICENTO
	yland		10a. State 10b. County	10c	City, Tow	n or Location						10d. Inside City Limits
	Mar Mar	ţō	WV Mine	ral	K.	evser						1 ☐ Yes 2 🕅 No
	1 28s	Director	10e. Street and Number	ıaı	IX		Zip Code			10g. Ci	itizen of What C	ountry?
	3a o		Route 5 Box 1	ДД Ant 1			2672	26	!		USA	
	hours after death with the Maryland turet', or Itema 23a or 28a-1 show at Examitter insult by multipled at	Funerai	11. Marital Status	12. Was Decedent Ever	n U.S.	13. Was De			(Specify Yes or Narto Rican, etc.)	0-	14. Race - Am	erican Indian,
(0	r He	표	1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No				an, Mexican, Pu	erto Rican, etc.)		Black, Whi	te, etc.
8	urs a	Ď	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1 🗆 Yes	2 💢 №	Specify:			Specify:	White
Ò	be filed within 72 hours after death with the Marylan stal Hygiene. ed other than "natural", or itema 23s or 28s-1 show event, the Medical Expiritive rotal by notified at	Completed	15. Decedent's Ed		16a.	Decedent's U			, .	16b. F	Kind of Business	
7	within 7 ene. than "n	pie	(Specify only highest gra	College (1-4or 5+)	-	(Give kind of life. DO NO)	work done i use retired	during most of w d)	rorking			
7	the piece	E	O O	College (1-401 5+)		Inf	ant				None	
D	e filed within al Hygiene. I other then "	a	17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Middle	e, Maidei	n Sumame)	
<u>a</u>	should be nd Mental marked c	To B	Shane	Andrew	V	<i>l</i> hittak	er	Ang	el M	arie	Ju	dy
Baltimore, Maryland 21215-0036	ges 1 and 2 should it of Health and Men it item 27 is marke or other traumatic	-	19a. Informant's Name/Relationship (	Type, Print)	19b	Mailing Addre	ss (Street	and Number or	Rural Route Numi	ber, City	or Town, State,	Zip Code)
Š	and 2 salth a n 27 is		Angel M. Whittake	r / Mother	F	oute 5	Box	144. Ap	t 1, Key	ser.	WV 26	726
ē,	of Healitem		20a. Method of Disposition	20	b. Place of	Disposition (#	lame of		Date	_	ocation - City or	Town, State
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₽	permit. Pa Departmer Important: Iny injury	. 0	4 □ Donation 5 □ Other (Specification 21. Sprature of Funeral Service Licer		umber				/16/2010		umberla: Funeral	Home, P.A.
Ba	permit. Pages Department of I Important: If ite any injury or of	Ü.,	A NA A	mod					et, Cumb	•		21502
_	12.4		230 Barti Stratha diagona	Uson	lanth Do						110, 110	Approximate
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.	eath. Dor	iot enter the ir	ode or dyin	ig, such as cardi	ac or respiratory i	arrest,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Cardea	Sa	scul	as		allap	Sa		
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence	200		1				
		_	Sequentially list conditions,	b. Dever	٤	Re	ma	burk	ty			
	Si W	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a con	sequence o	ot):			8			
	ecute and -tran	can	Cause (Disease or injury that initiated events resulting in death) Last	c		0						
ွှ်	sian surial	Û		Due to (or as a con	sequence	or):						
8760,	icate be executed physician and s the burial-transit	dicai	•	d								
9	eath certific attending p	Mec	IF FEMALE:									<u> </u>
Вох	tend tend	an/	23b. Was decedent pregnant	23c. If yes, outcome of pre 1□Live birth 2□F		3 □Ectopic	pregnancy	,			23d. Date of de	
	ed fo	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time 9□Unknown		5 Other					Month	Day Year
о. О.	at the	Physician/Me	9 □ Unknown				·					
Ś	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as	by 6	Part II. Other significant conditions c	ontributing to death but not	resulting in	the underlying	cause give	en in Part I.	23e. Did	tobacco	use contribute t	o the cause of death?
5	equir en si ould I	ed							1 🗆	Yes 2	ØNo 3□P	robably 4 Unknown
Records,	aw re s be	Completed							24a. Wa:		24b. Were a	utopsy findings available
Ä	The lay te has age 2	E							perf	ormed?	death?	completion of cause of
		0	25. Was case referred to medical					26 Place of D	1 ☐ Yes eath (Check only		)	s 22 No
5	Physician: The la r this certificate ha ral director, page 2	To B	examiner? 1 ☐ Yes 2 Ø No	Hospital: 1 ☑ Inpatient		toationt 3	Othe	or.	Home 5 ☐ Res		€ □Other /Sec	north I
Division of	<u> </u>	늘	27. Manner of Death	28a. Date of Injury (Month, Day Yea			28c. Injun Work		28d. Describe			жиу
o	fun Affe	Ę.	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		r) Ir	njury M		k? Yes 2 □ No				
2	or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be		At home, fai	rm, street, fact	orv. office		28f. Location	(Street a	nd Number or R	ural Route Number,
ă	after after Direction	Certification:	4 Homicide	building, etc. (Sp	ecify)		,		City or To	own, Stat	e)	
	Hospital		29a. Certifier 1 Certifying Ph	ysicien: To the best of my	knowledge	death occurre	d at the tim	ne, date and pla	ce, and due to the	cause(s	and manner a	s stated.
	T 4 F 0	edical		niner: On the basis of exame and manner stated.	nination and	or investigati	on, in my o	pinion, death oc	curred at the time	, date an	d place, and du	e to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1 , .	-//	<i>i</i> / 2	9c. License	e number		29d. Da	ate signed (Mon	th, Day, Year)
	- S - O		1 Akal	1/1/10	///	i.	1,2	736		,	7/151	10
	. 1		1 WW	/ week			10-	136			1101	/ -
4	14		30. Name and address of person who of Dale Wolford,				z Ron	d Cumb	erland,	MD	21502°	
11			31. Date filed (Month, Day, Year)	32. Registrar's Si	anaturo.		. noa	a, cumpe	LI Lanu,	<u></u>	<u> </u>	
	Sta Registr		JUL 16 2010	Je_ce_A	9	arked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ams 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 V Months Days Hours Washington. 77 Director 578-42-9962 04717/1933 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD PG Hyattsville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7405 18th Avenue #101 20783 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian Armed Forces?

1 Yes 2 XNo Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 🗆 Yes 2 🛶 No Specify: Specify: Black Completed 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Phone Operator Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James lee Henietta Hackney permit. Page 1 and 2 should t Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Herbert/ 6711 Larkspur Road; Suitland, MD 20746 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State any injury or 5 Other (Specify) Resurrection Cemetery 07/19/2010 Clinton, Maryland 21. Signi 22. Name and Address of Facility Freeman Funeral Services e of Funeral Service Licenses 4594 Beech Road; Temple Hills, Md 20748 23a. Part 1. Et er the disease, or complica ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between sho k, or leart failure. List only on calediate Savse (Final Immediate Onset and Death Physician/ disease or condition resulting in death) Due to (or as a consequence of): hmio Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury deconditioning certificate be executed the burial-transi that initiated events resulting in death) Last attending physician Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 menths? Pregnant at time of death signed by the at d be detached fo P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records. Completed 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 Yes 2 No Yes or Attending Physician: of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Netural injury work? 5 Pending 1 Netural
2 Accident
3 Suicide
4 Homicide Division 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Stertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

death (Item 23a) (Type Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien 0 1 0 State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 12, D2/010 2259 Albert M Young Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 Hours June 123, Year 933 South Carolina Director 577-42-2002 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Manyland ment of Health and Mental Hygiene. and tifter 275 is marked outher than "natural", or items 23a or 28a-f sho and if item 277 is marked outher than "natural", or items 23a or 28a-f sho uny or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2008 C Street NE 20002 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 A No Specify. 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
National 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Government Association Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William M. Young Edna L. Newman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theodore N. Young/ Brother 2008 C Street NE Washington, DC 20001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State **Glenwood** 4 Donation 5 Other (Specify) Washington, DC 21. Sig ture of Funeral Service Licen 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019 23a. Part Letter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ ARDIDPULMONALY disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** TICEMI Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Due to (or as a consequence of, Cause (Disease or iinjury that initiated events or Attending Physician: T e law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Day Month Vear Pregnant at time of death 5 Other (specify) leral Director; After this certificale has been signed by the filled in by the funeral director, p. ge 2 should be detached 9 Unknown 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🛛 No 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral director. 27, Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 29a. Certifier Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Norse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certific 29c, License number 29d. Date signed (Month, Day, Year) 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25A

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

To the within 2 5

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar 30. Name and address

31. Date filed (Month, Day, Year)

erson who cor

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ed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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July 17, 2010

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Division	al or Attend s after death Il Director: /			Could not b determined	e 28e. Place of Inj building, et	ury - At hou	me farm st	reet, factor	y, office		2	28f. Location ( City or Total	Street an vn. State ORE,	d Number or L = 95	Rural Rour	4 50 .8
7	No the Hospital or within 24 hours after To the Funeral Dire completed filled in b	Medical	(Check 2 ☐ Me	dical Exami	sician: To the best o	examination	and/or inve	stigation, in	my opinio	<ul> <li>n. death oc</li> </ul>	curred at	the time date:	and place	and due to t	he cause(s)	and manner stated
	vithin 2 To the		only one) 3 L Cer 29b. Signature and title of o		se Practioner: To the	best of my	knowledge,		rred at the License		and place	e, and due to th		s) and manner te signed (Mo		/ear)
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			30. Name and address of p	ney	MD	22	-904	Print)	reev	re S	tree	X B	alti	mor	e,M	DZ1201
	Stat Registra	~	31. Date filed (Month, Day, NAUG 022	rear)	32. Registr	ar's Signati	bark.	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Aug 1 2010 Ralph Arthur Arbaugh 2:30A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sykesville Brinton Woods Nursing Carroll Home Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 XM 2 🗆 F Hours 220-16-3613 12-10-1925 Director 84 MD Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic event. 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Carroll MD Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2119 Littlestown Pike 21158 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Specify: white 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Road Dept Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph William Arbaugh Daisy Mae Stimax 19a. Informant's Name/Relationship (Type, Print) 21158 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary N. Arbaugh-wife 2119 Littlestown Pike, Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Lake View Memorial 8/4/10 1 Deurial 2 Cremation 3 Removal from State Sykesville,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Licenses 22. Name and Address of Facility Fletcher Funeral Home Thomas 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each Immediate Cause (Final Onset and Death PROSCLAPTIC Physician disease or condition resulting in death) Medical Due to (or *s a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by been signatures 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s certificate 1 ☐ Yes 2 ☑ No 2 = Be ( 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Avursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ျ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Mann f Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Accident
Suicide 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director. /
completed filled in by the ? 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 20806 address of person who completed cause of death (Item 23a) (Type, Print) Persksku 21136

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 2 State of Maryland Department of Health and Mental Hygiene 20 | 0 certificate of Death Reg. No. 23918 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Mont O: ZIAM Charles Anderson Sr. 20 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death ltimore Sinai Hospital of Baltimore n/a 6. Sex 1 X M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Min. Mante Day Year SC Director 220-30-6214 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified Baltimore MD. n/a 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 21216 2608 Roslyn Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces2-1 ☐ Yes 2 ☑No Black, White, et 1 Never Married 2 Married Saltimore, Maryland 21215-0036 African-American 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 □ Divorced 50 Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) rould be filed within 72 Ind Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Campbell's Construction Construction Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Bell Darhams Owens Anderson permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is mar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pastor Shelly M. Anderson/Daughter <u>2608 Roslyn Avenue, Baltimore, MD 21216</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State King Memorial Park 7-10-2010 Woodlawn, MD Donation 5 Other (Specify) 22. Name and Address of Facility Wile Funeral Hone P.A. of Balto. Co. ure of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line ediate Cause (Final Approximate Interval Between Onset and Death Physician/ Subd disease or condition resulting in death) ura Medical Due to (or as a consequence of): Examiner APPROVED BY ME Sequentially list conditions. Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury CENTIFICATION that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical  $\mathcal{A} / \mathcal{A} \wedge \mathcal{A} / \mathcal{A}$  Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available autopsy performed prior to completion of cause of death?

1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 To No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury Certificate: 27. Manner of Death 28d. Describe how injury occurred Subject fell out of bed. 28b. Time of 28c. Injury at 1 Natural 2 Accident work?
1 Yes 2 No 5 Pending 07/01/2010 **Unknown**M Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Boute Number, City or Town, State) 2608 Roslyn Avenue Baltimore, MD determined Home Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4006 42 JULY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAI HOSTITAL IRAWMA SURCERY JAMSHED 31. Date filed (Month, Day, Year) State 3 0 2010 Registrar

			For State Registrar	State of	Marylan	-	artment of I		and M		giene Reg. No	2010	239	919
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-	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. Ia	ast birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birt	h	9. Birt	hplace (State o	r Foreign
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lar	should be file n and Mental I 7 is marked o raumatic eve	78	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street	and Numbe	er or Rural	Route Number	; City or 7	own, State, Zip	Code)	
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Impartment of Heath and Mental Hygiene. Impactant: I fire Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1.8	4 Donation 5 Other (3		171		Mem Cem.  Name and Addre			/2010		land, l		
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			23a. Part 1. Enter the disease, of shock, or heart failure. List	complications that cau only one cause on each	sed the deat line.	h. Do not ente	er the mode of dyin	ig, such as	cardiac or	respiratory arr	est,		Approximat Interval Bet	ween
~-P	h sician/ Medical	S 16	Immediate Cause (Final disease or condition resulting in death)		ementi.								Onset and I	Jeath
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<b>⋽</b>	nysic his ce al dire	မ	1 ☐ Yes 2 ☐xNo			ER/Outpatier	nt 3 🗆 DOA Oth	er: 4 👿 No	ursing Hor	ne 5 🗆 Resid	lence 6	Other (Spec	ify)	
<u> </u>	ding F h. After 1 funera	Certificate:	27. Manner of Death 1 ∰Natural 5 ☐ Pendii	9	injury Day, Year)	28b. Time of injury	28c. Injur work	ζ?		8d. Describe h	ow injury	occurred		
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Division of Vital Records, P.O. Box 68760	al or Attendir s after death. al Director: Af ed in by the fu		4  Homicide determ		etc. (Specify		oo, ractory, omeo		1	City or Tow	n, State)	TIBITION OF THE	Q TOSTO TOSTO	. 6.,
	Io the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th	Medical		Physician: To the best										nner state d
	the H nin 24 the Ft the Ft	Mec	only one) 3 Certifying	xaminer: On the basis of Nurse Practioner: To										iller stated.
	with Con		29b. Signature and title of certifie	· Ca	P	-0	29c. Licens				29d. Date	signed (Month	n, Day, Year)	
	0							25079			07/	28/2010	)	
	4		30. Name and address of person Dr. Don Yablor					300	Lanhs	am, MN	2070	6		
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	Registra	ar	AUG U 2 2010	Lenan	1. 4									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death an/ Month 1055 hrs ner Mary Royster Brown July 26, 2010 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Sinai Hospital Baltimore N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Months Days Hours 217-50-1657 Country) Maryland 1 M 2X F 66 28, 1943 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 No Maryland N/ABaltimore Funeral Director 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 5409 Falls Road Terrace Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married 2 X Married 2 X No Yes If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed 4 Divorced Specify: White ≥ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 4 vears Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, MD 2121: permit. Pages I and 2 should be fil Department of Health and Mental I Important: If item 27 is marked Be John Reitz Royster Ellen Tickner 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W. Taylor Brown (husband) 5409 Falls Road Terrace Baltimore, Maryland 21210 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Green Mount Crematory 7-29-10 Baltimore, Maryland Donation 5 Other Specify. ²² Name and Address of Facility Mitchell-Wiedefeld Funeral 6500 York Road Baltimore, 21, Signature of Funeral Service Licensee Home In Maryland 21212 Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial -UNPENDED **AMENDED** IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Year Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has death? performed 1 ✓ Yes 2 No 1 🗸 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other: 2 V ER/Outpatient 3 this 1 🗸 Yes 28a. Date of Injury Jul 26, 2010 After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification Subject struck by tree limb Natural 1007 hrs 1 Yes 2 ✓ No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) 5409 Falls Road Terrace, Baltimore, MD (Specify) Yard determined 4 __ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

Box 68760, Records, P.O. Division of Vital the Funeral

State Registrar DHMH 17 Rev 1/2001

**OCME 2006** 

OCME

Bussell

29b. Signature and title of certifier

Jack Titus MD.

and manner stated.

Deputy Chief Medical Examiner

for Dr. Jack Titus

32. Registra 's Signature

MB

30. Name and address of person who completed cause of death (Item 23a)

**ORIGINAL** 

2 🗸 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month. Day. Year)

July 27, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23921 Certificate of Death 2. Date of Death 9 <u>2010</u> Physician/ Shirley 10:55 PM Mae Bowles July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Towson Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Dec. 28, 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In vrs. last birthday) Funeral Days Min. 1 □ M 2 🂢 F 216-38-4545 67 Director Usual Residence of Decedent 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3902 Link Avenue U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Completed by 1 Yes 2 X No Specify: Specify: White and Mental Hygiene. 3 Widowed 4 X Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Hospital <u> Admission Clerk</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Claude Allen Tingler Gretta Kemper permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3902 Link Avenue Baltimore, Maryland Nader Farzad (son-in-law) injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Park 8-3-10 Baltimore, Maryland 22 Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21. Signature of Funeral Service Licenses 21212 23a. Part 1. Let the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ UNA disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Dav Year Pregnant at time of death 1 Yes 2 1 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? EMPHYSEMA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Unursing Home 5 Residence 6 Other (Specify, Hospital: 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. JULY 30, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

BALTIMORE, MO 21204

DANIEUE DOBERMAN, MD 6701 N CHAPLES ST, SUITE 4105

32. Registrates Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last Physician/ ARE 0030 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death **Baltimore** Randallstown Seasons Hospice of Baltimore 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Funeral Days 1 🗆 M 2 🔽 F Hours Director 1923 Maryland 220-22-1982 Oct 7 Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No **Baltimore** Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A 3310 Benson Avenue 21227 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 🙀 No Maryland 21215-0036 1 Tes 2 X No Specify: Black 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **Baltimore City** Custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Brown James William Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1527 King William Drive Baltimore, Maryland 21228 Albert Jones Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 5 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, injury o 07/31/10 Lansdowne, Maryland 4 Donation 5 Other (Specify) Mt. Zion Cemetery 22. Name and Address of Facility Estep Brothers Funeral Service, P Eutaw Place Baltimore, Mc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician seu mon14 disease or condition Medical resulting in death) o (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 No page 2 should be detached g Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24 hours after death. Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 2 No Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital Other: ည 1  $\square$  Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 4 Nursing Home 28a. Date of injury (Month, Day, Year) Manner of De th 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 🞾 Natural 5 Pending injury М 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined 24 hours Medical

Division of Vital Records, P.O. Box 68760

State Registrar

29a. Certifier

(Check

only one 29b. Signature and title

within 2

and address of person who completed cause of death (Item 23a) (Type, Prig

🖙 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23aPtII,25 per me.g905,07/30/2010dhb

Certificate of Death

Reg. No. For State Registrar 23923 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $11^{\text{Day}} 2010^{\text{Year}}$ Month July Veronica J. Bassett 0950 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2240 Pinefield Road Waldorf Charles Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year March 20, 1 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XX Hours Min. Months Days Yrs. Director 579 62 4532 1948 Washington DC Usual Residence of Decedent r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Charles Waldorf 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 2240 Pinefield Road 20601 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married "natural", or 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify 3 Divorced Specify: Completed **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
77 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Human Resources Feder1 Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Smith Barbara Grisby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other traus Bernard Bassett (Husband) 2240 Pinefield Road, Waldorf, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Hurial 2 ☐ Cremation 3 ☐ Removal from State Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gardens: July 15, 2010 21. Signature of Licen 22. Name and Address of FacilityLee Funeral Home, Inc. 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 🗀 Fetal death in the past 12 months? Month Day Vear Pregnant at time of death 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dispare 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes

Physician/ Medical **Examiner** 

Maryland 21215-0036

Baltimore,

attending physician for use as the burial the ģ cate has been siç ; page 2 should b

director,

To the Hospital or Attending Physician: The law

Division of Vital

Completed by this certificate Be ည Certificate: within 24 hours after death

To the Funeral Director: /

Dialoctes 25. Was case referred to medical examiner?

Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA

28c. Injury at work?

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 X No

Other: 4  $\square$  Nursing Home 5  $\bowtie$  Residence 6  $\square$  Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Conflying Nurse Practioner To the best of my hill weldge, Just in personned at the fine date of plane and due to the eause(s) and memor as state 29c. License number 29d. Date signed (Month, Day, Year) D0028035

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BASIRMOHMAD F. KOLIA M.D.

28a. Date of injury

(Month, Day, Year)

9135 Piscutaway Rd. #310 CLINTON MD 20735

July 12, 2010

State Registrar

Medical

B1. Date filed (Month, Day, Year)

5 Pending

Investigation
6 Could not be

determined

27. Manner of Death

1 Natural
2 Accident
3 Suicide
4 Homicide

inly one)

29a. Certifier

3 Registrar's Signature

MO

28b. Time of

		1 - For State Registrar Amend It	State of Ma cem 25 per	aryland /	Depa 906, (	rtment of 1 18/02/201 tificate of L	lealth and <b>0dhb</b> Death	Mental Hy	giene Reg. No. 2 (	)   0	23924
Physici Med		1. Decedent's Name (First, Middle, Las Margaret Bocko				·		2. Date of De July	_	20 <b>10</b>	3. Time of Death 3:30AM M
Exami		4a. Facility Name (if not institution, give Transitions Healt	,			4b. City, Town, or Sykesvi		h	4c. Cour	nty of Death Carro	
Funera Directo			ex □ м 2 <b>X</b> F 96	e (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th V Yea <i>r)</i> 0 1914	Com	nplace (State or Foreign ntry) RI
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ath with ems 23a	Funeral Director	6420 Freedom Aven	12 Was Decedent F	ver in LLS	13 14	2: /as Decedent of Hi	1784	pocify Voe or No-	lu n	US	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any once.	ted by F	1 Never Married 2 Married 3 M Widowed 4 Divorced	Armed Forces?  1 ☐ Yes 2 X☐  If Yes, Give  Year or Dates.		If	Yes, specify Cuba	n, Mexican, Puerl	to Rican, etc.)	В	lace - Americ lack, White, ify: whi	etc.
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arylai	2	Vincenzo  19a. Informant's Name/Relationship (Ty		1 1	9b. Mailine	Address (Street a			utier	State Zin	Code)
e, Mand 2 sh Health a Hem 27 is		Mrs. Betsy Lee Ru	do (Daught	er) 6	420	Freedom A		ykesvill		21784	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. important; If item 27 is marked other than "natural", only injury or other traumatic event, the Medical Exam proces.		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification 5)	Removal from State	ceme	ine F	atory or other place Park Cem.	11	27/2010	Baltim	ore,	MD
Ball permi Depar Impo		21. Signature of Funeral Service Ligens  Buan L Ha	ist MOO	764	Ρ.	Name and Addres	95 Sykes	sville, l	MD 2178		Chape1
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Medical Examiner		resulting in death)	Due to (or as a	consequence	e of):		1 //				for
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58 / 60 rtificate b ling physic	/Medical	IF FEMALE:	d								
ords, P.O. box 68/ requires that the death certific been signed by the attending I should be detached for use as	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		Ectopic pregnance Other (specify)	У			Date of deliv Month	very Day Year
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VITAI Iysician iis certifi director	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 🗆 ER/0	Outpatient	Othe	r: 4 Nursing H	ck only one)  Iome 5 Resid	lence 6 🗆 Ot	ther (Specify	()
On OT nding Pr ath. r: After th	Certificate:	27. Manne of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injur (Month, Day,		. Time of injury	28c. Injury work? M 1 🗆	at	28d. Describe h			,
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Examination) 3 Certifying Nurse	ner: On the basis of ex	amination and	or investig	ation, in my opinio	n. death occurred	at the time, date a	nd place, and d	due to the car	use(s) and manner stated.
withir to comp		29b. Signature and title of certifier	willing	0	250,00	29c. License			29d. Date sign	ed (Month, i	
	8. 0	30. Name and address of person who co	ompleted cause of de	ath (Item 23a)	(Type, Pri			vezmii	ister		
Sta Registr		31. D te filed (Month, Day, Year)  AUG 0 2 201	33 Hegistrar	's Signature	ba	Suite Med	/ 1 1	, , , , , , , , , , , , , , , , , , ,	'	,	

			- State Amend Item 25 per np, g906	3,08702 Cen	<b>1/2010dhb</b> tificate of D	lealth and M Death	lental Hygie Reg.	ne No 2010	23925
	Physicia		Decedent's Name (First, Middle, Last)     BARBARA ELLEN BLANKEN	SHIP			2. Date of Death	2 ⁰ 4 2010	3. Time of Death 5:00aM
	Medic Examin		4a. Facility Name (if not institution, give street and number)			Location of Death		4c. County of Deat	h
	Funeral		8 3 1 6 PHILADELPHIA ROAD  5. Social Security Number   6. Sex   7. Age (In yrs. la.	st birthday)	ROSEDA If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	BALTIM 9. Bir	thplace (State or Foreign
ı	Director		231 44 0681 1 M 2 XF 75  Usual Residence of Decedent	Yrs.	Months Days	Hours Min.	067277	935 VÎ	KGINIA
	yland f show ed at	ctor	10a. State 10b. County 10c. City	, Town or Loc					10d. Inside City Limits
	he Mar or 28a	Director	MD BALTIMORE R  10e. Street and Number	ROSEDA	10f. Zip Code		10g	. Citizen of What Co	1 Yes 2 XNo
	h with the ns 23a must b	Funeral	8316 PHILADELPHIA ROAD		212			USA	
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	lf lf	/as Decedent of His Yes, specify Cubar ☐ Yes 2 XNo	spanic Origin? (Spec n, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: WH	e, etc.
15-(	72 hou an "nat Medica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give ki	ent's Usual Occupa ind of work done d O NOT use retired)	ation Juring most of working	ng 16l	o. Kind of Business	Industry
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lanc	d be file fental H irked o	10 B	17. Father's Name (First, Middle, Last) WILLIAM J. VAUGHN			18. Mother's Name ELSIE	(First, Middle, Maid GUITII	,	
, Maryland 21215-0036	d 2 should alth and N 1 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) DREMA K. ANDERSON/DAUGHTER			nd Number or Rural			MD 21237
Baltimore,	Page 1 an nent of He int: If iterr iry or othe		1 Burial 2 Cremation 3 Removal from State	emetery, crem	sition (Name of eatory or other place	e)		Location - City or	Town, State VIRGINIA
Balti	permit. I Departn Importa any inju		21. Signature of Fun miss viry Licentee				CH/ROSEI	DALE FUN	ERAL HOME
ı			23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.		0		r respiratory arrest,		Approximate Interval Between Onset and Death
	Medical		disease or condition resulting in death)  a. Due to (or is a consequence)		Failur	2			2 Wrs
	Examiner	er	Sequentially list conditions,  Due to or as a consequence.	anna efti					years
	uted Id ansit	Examiner	If any, heading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	ence out					
0	icate be executed physician and s the burial-transit	edical Ex	resulting in death) Last Due to (or as a consequence)	ence of):					
8760	tificate ng phy as the	Medi	F FEMALE:						
. Box 68	the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	Ideath 3 🗌	Ectopic pregnance Other (specify)	у		23d. Date of de Month	livery Day Year
ls, P.O	uires that to r signed by		Part II. Other significant conditions contributing to death but not resu	ulting in the un	nderlying cause giv	en in Part I.			the cause of death?
Division of Vital 'Récords, P.O.	sician: The law req certificate has bee lirector, page 2 shou	Completed by					24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
ital,	sician: certific rector,	Be	25. Was case referred to medical examiner?  1  Yes 2  No  Hospital: 1    Inpotient 2  III		Othe	ace of Death (Check	,		DALIGHEDS TO
of V	ng Phys ter this neral di	rte: To	i i iipatierit 2 i i	ER/Outpatient 28b. Time of injury	28c. Injury work′	at 2	me 5 A Residence 28d. Describe how i		ify) DATE HOW
sion	I or Attending Physician: after death. Director: After this certific i in by the funeral director,	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At hor	me, farm, stre		Yes 2 □ No	28f. Location (Stree	t and Number or Ru	ral Route Number,
Ď	ital or Jus after ral Dire		building, etc. (Specify)				City or Town, S	tate)	
4	To the Hospital or within 24 hours at To the Funeral D completed filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle construction only one) 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practioner: To the best of my	and/or investig	gation, in my opinio	n, death occurred at	the time, date and p	ace, and due to the	cause(s) and manner stated.
	Vith To th	_	29b. Signature and title of certifier		29c. License		29d.	Date signed (Mont	
	Ži.		30. Name and address of person who completed cause of death (Item	23a) (Type, Pr	RO8	1140	01	2211	0-10
	Stat		31. Date filed (Month, Day, Year)  2. Registrar's Signature	ure	A A	14(1)	$\propto$ 1	dd4	
	Registra	ar	AUG 0 2.2010 Resure 3.	grav	res -				

State of Maryland / Department of Health and Mental Hygiene 23926 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day  $J\overset{\mathsf{Month}}{u}\overset{\mathsf{l}}{l}\overset{\mathsf{y}}{y}$ **Physician** 2010 ear 26, 8:30 AM James Anthony Brown /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Caroline 204 Routzahn Lane 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 □ F ^{Year)} 1934 158-26-9000 75 Virgińia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural" --- any iljury or other traumatic excent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Caroline Federalsburg 1 ☐ Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21632 USA 204 Routzahn Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Specify: black If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) chicken farm unk laborer 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk Be P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sadie Baltimore - friend 704 Fairhaven Court; Federalsburg, Maryland 21632 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4□Donation 5₺Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 21. Signature of Funer Larvice Licensee Ronal d St. Wye Director 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Probable **Physician** Coronar disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dut to (or as a sonsequence of): Examine The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of). ing physician a Box 68760, Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) P.O. signed by the a 1 □Yes 2 □ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ► No 24a. Was an this certificate has autopsy page 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation hours after death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier n who completed cause of death (Item 23a) (Type, Print) Preston MD 21655 136 Timoth. Silie eK MD 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#8perFH, G906, 8/2/2010, WS State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $0.7^{Month}$ Day 28 MARY FRANCES BARKER 2010 2:29  $A^{M}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 158 Dunlap Rd. Anne Arundel Pasadena 8. Date of Birti9/19/1935

(Mopth, Day, Year) 2 F

Selection Country)

9. Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) **Funeral** 1 □ M 2 💢 F Days Hours Min. **Director** Yrs. Maryland 216 34 2003 74 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Pasadena Anne Arundel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 158 Dunlap Rd 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. . or ! Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: and Mental Hygiene. 3 Divorced 4 Divorced Year or Dates White permit. Page 1 and 2 should be filed within 72 hour popartment of Health and Mental Hyglene. Important: If item 27 is marked other than "natuu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Secretary MD MVA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mollie Frances Jowers Desmond C. Young, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurie Gonce - daughter 2629 Evergreen Rd Odenton, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MeadowridgeMem Pk 7/31/10 Elkridge, 22. Name and Address of Facility GJ Gonce Funeral Home, 169 Riviera Dr Pasadena, MD 21122 21. Signature of Furtaral Service Licensee PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Chemic Cardiomino disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence oi). To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending the second. attending physician and for use as the burial-transil Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ludrey disease sta Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performe Yes 2 No 2 🗌 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural Accident 5  $\square$  Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Siz Patchie My Pasadena MD 2/122 M 10 State Registrar

P.O. Box 68760

**Division of Vital** 

10-05553 Matthew Booher Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

accinow Edding		1- For State Registrar	Ole	ate of i	viaiyiaiiu	-	tificate of		and Men	arriyy		, _{No.} 2	010	23928
Physici		Decedent's Name	e (First, Middle	e,Last)	•						Date of Death		Year	3. Time of Death
edical Exami	iner	Matthew Bo	oher							J	luly 25, 20	10	real	0612 hrs
		4a. Facility Name (if		_					n, or Location of	Death			County of Death	-
		Baltimore W	/ashington	Medical	Center			Glen Bu				An	ne Arundel	
Funeral Director		5. Social Security N 080.74.435		6. Sex		e (In yrs. la 26	ast birthday) Yrs		Year If Under Days Hours	Min.	Nov 8,		Foreig	hplace (State or n untry)
		Usual Residence of	Decedent							1 1				
v any		10a. State	10b. County			10c. City,	Town or Locat	ion						10d. Inside City Limits
and F shov	ō	MD	Anne Ar	undel		Glen	Burnie							1 Yes 2 No
Maryl 28a- d at c	ect	10e. Street and Nun	mber					10f. Zip Co	de		100	g. Citize	n of What Cour	try?
the 33 or	ä	419 Hidden	brook Dr	., Apt	G			21	1061				USA	
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status  1XXX Never Marrie	nd 2 1 140		Was Decedent Armed Forces?				of Hispanic Origi uban, Mexican,			14	Race - Americ    White, etc.	can Indian, Black,
r deat	핊			1	Yes 2	XX No					,			
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hour Fratu	ted	15. Decedent's Ed Elementary/Seco			ollege (1-4 or				cupation (Give ki g life. DO NOT u			16D. KIN	d of Business/Ir	ndustry
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d wit	Son	17. Father's Name (	First, Middle,	Last)				00		Name (Fi	rst, Middle, Ma	aiden Su		
215 oe file stal H ked o	Be (	Robert M. I	Booher						Judith	M. Ci	rookshan	ks		
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MD 12 sh th and 1.27 is		Judith Cro	okshanks		Mother		419 H	iddenbro	ook Dr., A	pt G,	Glen Bu	rnie,	, MD 2106	1
Te, Theal		20a. Method of Disp	_	2 🗆 Da	mayal from Ch		Place of Dispos		of cemetery,	Da	ate	20c. Lo	cation - City or	Town, State
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alti mit. partm ports ury o		21. Signature of Fur	neral Service L	ic nsee	0	/	22 -	lame and Add	dress of Facility	РΑ	-			-
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Physician		23a. Part I. Enter the	disease, or o	complications on each line	ns that caused e.	the death.	Do not enter the	ne mode of dy	ying, such as car	diac or res	spiratory arres	t, shock	, or heart	Approximate Interval Between Onset and
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ansit		events resulting in d	death) Last	d.	o (or as a conse	equence or	).							
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687 ertific ding p	au/	23b. Was decedent p past 12 months?		1 [	Live birth			tal death	3 Ectopic p	oregnancy		M	onth D	ay Year
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the de	Phy	Part II. Other signifi	icant condition			but not re	sulting in the u	nderlying cau	ise given in Part	i i	23e Did toba	acco use	e contribute to t	he cause of death?
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ivisior or Attendather death Director:	흲	2 Accident 3 Suicide		Jack of L	lul 25, 2010 8e. Place of Inj	ury - At ho	0530 hrs me, farm, stree	et, factory, offi	ice building, etc.	28f			Number or Rur	al Route Number, City
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Hosp 24 ho Fun etely f		1-11-11				_			e, date and place					
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical				e basis of exar nanner stated.	nination an	id/or investigati		nion, death occu	irred at the	time, date an	d place	, and due to the	cause(s)
	Σ	29b. Signature and t	title of certifier	) -	6	217			cense number				te signed (Mon	th, Day, Year)
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AMEND ITEM#20a-c, perFH, G90, 9/16/2010, WS

State of Maryland / Department of Health and Mental Hygiene

Amend Items 17a, b, 21, 22 per sa, 2906, 08/02/2010dnb For State Registrar Reg. No 2010 23929 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 05° 2010 6:00 AM Hazel Crawford Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Catonsville Manor Care If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M XX Hours Country) unk. 0(Month Day, Year) **Director** 65 Yrs 215-42-7949 Usual Residence of Decedent items 23a or 28a-f show ier must be notified at 10a, State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2X No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1525 N. Rolling Road 21228 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Crawford Black, White, et African ō 1 Never Married 2 Married Completed by 72 hours after 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 □ Divorced SpecifAmerican Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

11nk 16b. Kind of Business Industry unk . (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk. unk. Be Hazel Maryland 17. Father's Name (First, Middle, Last) unk. 18. Mother's Name (First, Middle, Maiden Surname) unk. ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Muhammad - son 3412 Auchentoroly Terrace, Baltimore, MD 21217 Baltimore, 20a. Method of Disposition Dec 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 X Other (Specify) in state cemetery, crematory or other place 8/14/2010 Crematory Glen Burnie, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Dater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Immediate Cause Final Onset and Death Physician/ CORIN ARY ANTE DUSGASE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner SNGED RUE HEAR GALLUSE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to lot as a consequence of the attending physician and hed for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed LERE BROVAS CULAR A CCIDENT Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery the Funeral Director, After this certificate has been signed by the atter expleted filled in by the funeral director, page 2 should be detached for i in the past 12 months?

1 Yes 2 No Dav Year 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1  $\square$  Yes 2  $\square$  No 3  $\square$  Probably 4  $\square$  Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☑ No Hospital: Other မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Sign ture and title of certifier 29c. License number ATTEMD M DOD 56944 JULT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fu TE TAM IND A BAZTIMONE MO 21257 300 tur on ? 31. Date filed (Month, Day, Year) . Registrar's Signature State AUG 0 2 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Everton Carlisle Cave S'CJAM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE MARITAN If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Months Min. Hours April Day (Year) 1944 220-94-8983 Barbados Director 66 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1X☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 633 N. Aisquith Street #6K 21202 Barbados 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: black 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) security law enforcement permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Winston Carlysle Cave Alma Prescod 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cecelia Patterson - wife 633 N. Aisquith Street #6K; Baltimore, MD 21202 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 X Donation 5 Other (Specify) atur of Fu eral Se 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore Street; Baltimore, MD 21201 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on electrical line. Approximate Interval Between Onset and Death Immediate Sause (Final Physician monar disease or condition Medical resulting in death) Due **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Doth Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Accident injury 5 Pending M 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 둳 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death  $J_{u1y}^{Menth}$  29, 2010Physician/ 9:00 A Nancy E. Cronin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suburban Hospital Montgomery Bethesda Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🖾 F Months Hours Min 68 March 31, Year) 42 Connecticut 049-32-0764 Director Usual Residence of Decedent or 28a-f show e notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 ☐ Yes 2 🔀 No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12432 Valleyside Way 20874 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Broker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William Cronin Marion Hogan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maureen Weintraub/Sister 13540 Stonebarn Lane, N. Potomac, Maryland 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State August 2, Cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Bethesda, Maryland 22. Name and Address of Facility Robert A. Fumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue 21. Signature of Funeral Service Licenses M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Small cell lung cancer disease or condition years Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Examine Due to (or as a consequence of): sician and burial-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? signed by the atte Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, of Vital æ 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending Division 2 Accident 3 Suicide Investigation 1 Yes 2 No within 24 hours after deatl To the Funeral Director. 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Franticner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Franticner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Franticner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29d. Date signed (Month, Day, Year) D43083 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9707 MEDIUL CENTER DR #300 ROCKMUE, NO ZOSSO 50:03 GESPICE NO 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

CRONIN, NANC

State of Maryland / Department of Health and Mental Hygiene 23932 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Carver Make July_ 23 2010 6:26 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
March 15,1920 North Carolina Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Days Hours 1**XX**M 2□ F Months Min 90 **Director** 239-22-8566 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director XXYes 2 □ No D.C. Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4708 10th Street, N.E. U.S.A. 20017 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XXXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □ Yes 2/CXNo Specify: ģ Specify: Black 3XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Security Officer ages 1 and 2 should be filed wi ent of Health and Mental Hygier It: If item 27 is marked other th y or other traumatic event, Its 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lula J. Smith Archie L. Carver 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Carver/Daughter 4708 10th Street, N.E. Washington, D.C. 20017 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or 07/31/2010 Brentwood, MD Ft. Lincoln Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall March Funeral Homes 4217 9th Street, N.W. Washington, D.C. 20011 t1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mitriosci Physician 2911 /Medical Due to (or as a consequence of) Examiner Sour nitrally is a manager if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) death certificate be executed and burial-trar Due to (or as a consequence of) the attending physician Physician/Medical as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? Month Year 5 ☐ Other (specify) 2 □ No P.O. 1 □ Yes law requires that the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 0 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate Belowkn 1 □Yes 2 PNo Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 □ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I cal 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2 cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed au 31. Date filed (Month, Day, Year) legistrar's Signatu State AUG 02 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23933 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Frances Dreisch 09:50 PM Medical Facility Name (if not institution, give City, Town, or Location of Death **Examiner** 4c. County of Death timore 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Hours Min (Month, Day, Year, an. 27. 1 Maryland 216-34-2990 Director 73 Jan. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be r Funeral 8223 Elko Drive 21043 USA items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status "natural", or ite Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Homemaker Own Home permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Francis J. Gray Eleanor K. Kenney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas F. Dreisch Son 8223 Elko Drive; Ellicott City, MD 21043 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🛭 Burial 2 🗆 Cremation 3 🗆 Removal from State New Cathedral Cemetery 7/31/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Sign ture of Funeral Service Licensee 1630 Edmondson Avenue: Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Month Year the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by othyroidism 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy batas Mallitus performed' this certificate 2 **N**O 2 N Yes or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 **20**No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Phopatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 🛮 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

only one) 29b. Signature and title

AUG

ed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

oton Ave. Ballimore Mo

28th/10 - 6:01 PM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 23934 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^D2010 July Elizabeth Kimball Drenner 28 2:21 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carrol1 Westminster Dove House 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Hours Min. 1 □ M 2 🙀 F Director 218-12-2561 86 Mary1 Usual Residence of Decedent ıral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Carroll Sykesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 21784 USA 6508 Ridenour Way East #30 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 Divorced Specify: White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Case Coordinator Red Cross Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed thrent of Health and Mental H rtant: If item 27 is marked ot njury or other traumatic ever Carolynn Staley Andrew L. Kimball 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10121 Lyons Mill Road; Owings Mills, MD 21117 19a. Informant's Name/Relationship (Type, Print) Andrea Drenner-Hanley-Daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th Baltimore, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 7/29/2010 Glen Burnie, MD 22. Name and Address of Facilin Sterling Ashton Schwab Witzke Tuneral Home of Catonsville, Inc. 630 Edmondson Avenue; Catonsville, MD 21228 ign ture of Funeral Service License Funeral Home of 1630 Edmondson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and bunial-tran Due to (or as a consequence of): sate has been signed by the attending physician page 2 should be detached for use as the bunal Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed this certificate 1 Yes 2 No 1 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 🗌 Yes 2 **□**√No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred thin 24 hours after death. the Funeral Director: After (Month, Day, Year) 1 Natural 5 Pending 1 🔲 Yes 2 🔲 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one and title of certific 29b. Signatur License number 28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster, MD 21157 Flavio Kruter, M.D. 555 South Center Street

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

10-05682 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Joseph Alexander Evans 2010 23935 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month **Medical Examiner** 1335 hrs Joseph Alexander Evans July 29, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2430 Christian Street Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 220-46-9968 1 XM 2 F 60 08/21/1949 CountrMaryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 XYes 2 No or 28a-f shov Maryland N/A Baltimore permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or items 23a or 28a-f sho Examiner must be notified at once. rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2430 Christian Street 21223 United States Funeral 11 Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 XMarried 1 X Yes 2 No 11 Yes, Give Year 1969-73 1 X Yes White Yes 2 X No specify: 4 Divorced Specify: ۵ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than event, the Medical 2 Quality Engineer Defense Contractor 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Joseph T. Evans Virginia M. Hale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2606 Cole Street Baltimore, Maryland 21223 Cynthia Evans - Wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Atlantic Crematory 07/30/2010 Glen Burnie, Maryland Donation 5 Other Specify. Signature of Funeral Service Licenses 22. Name and Address of Facility Dayid J. Weber 5311 Edmondson Funeral Homes P.A. Avenue Baltimore, Maryland 21229 Part I. Enter the disease opcomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one-cause on each line. Approximate Interval Physician Between Onset and /Medical a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - transi Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Chronic Alcohol Abuse Completed Records, has been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? death? r this certificate h ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Inpatient Other 1 Nursing Home 5 Residence 6 ✓ Other: Scene 2 ER/Outpatient 3 DOA 1 V Yes 2 No After 28a, Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural Director: d in by the f Pending 1 Yes 2 No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City

Death

Year

2 No

or Town, State)

29d. Date signed (Month, Day, Year)

July 30, 2010

within 24 hours at To the Funeral I

State

Medical

3 Suicide

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD.

Could not be

determined

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland	d / Depa <i>Cer</i>	artmen <i>tificate</i>	t of H	lealth i <i>eath</i>	and M	lental Hy	giene Reg. No.	010	23936
	Physici		1. Decedent's Name (First, Middle, La FRED	,	HRLICI	н					2. Date of De JULY	eath Day 29	2010	3. Time of Death  1:40 P M
4	Medi Exami		4a. Facility Name (if not institution, given		IKLICI		4b. City,	Town, or	Location of	of Death	3011		unty of Death	1.40 1
1			STELLA MARIS H	OSPICE			TIM	ONIU	JM			BA	ALTIMOR	E
	Funeral			Sex 7. Ag 1 ☑ M 2 ☐ F	e (In yrs. las 86	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir		9. Birthp Coun	place (State or Foreign try) MD
	Director		Usual Residence of Decedent	Λ	00	173.					10/20/	1923		MD MD
	land Fshow	ţ	10a. State 10b. County		10c. City,	Town or Loc	cation						1	0d. Inside City Limits
	Mary 28a-1 otifie	Director	MD BALTIM	ORE		rowson								1 🗆 Yes 2 🔀 No
	ith the	ral	10e. Street and Number  ONE RUSHMORE CO	upm			10f. Zip	Code 21204				_	of What Cour	itry?
	s after death with the Maryland s after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent I	ever in U.S.	13. V				gin? (Spe	cify Yes or No- Rican, etc.)		JSA Race - Americ	an Indian.
ي	fer de amine	by	1 🎇 Never Married 2 ☐ Married		No		Yes, speci				Rican, etc.)		Black, White,	
⁾ <b>p.m.</b> 215-0036	ours a tural al Exal	sted	3 Widowed 4 Divorced	If Yes, Give Year or Dates.								Spe	AATI	ITE
P.II.	72 hc	Completed	15. Decedent's (Specify only highest of	rade completed)		16a. Deced (Give F	lent's Usua kind of worl O NOT use	k done di	ition uring mosi	t of workir	ng	16b. Kind o	of Business Inc	dustry
1:40 M 212	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at		Elementary/Seconday (0-12)	College (1-4 or 5	i+)	DENTI		rounday				DEN	TAL	
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2010 Maryland	uld be I Men narke natic	-	VICTOR		RLICH				JEN				KOLKER	
2010 Man	1 and 2 should be filed within 72 hour if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical		19a. Informant's Name/Relationship ( DR. JEFFREY PE)		JEU		-				Route Numbe	•	•	Code) 1783
	T and f Heal		20a. Method of Disposition		20b. Pla	ace of Dispos	sition (Nam	e of	- 1		ate		on - City or To	
ξ? E	Page Tent o		1 X Burial 2 ☐ Cremation 3 I 4 ☐ Donation 5 ☐ Other (Spec	☐ Removal from State cify)		metery, crem VNA CO					/2010		IMORE,	
JULY 29, Raltimore	permit. Page 1 a Department of H Important: If ite any injury or ott		21 Signatur) of Funeral Service Lice			22	. Name and	d Address			L LEVIN			
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4		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Sue to (or as c. Due to (or as d.										
H. Box 687	ne death certifica / the attending p ched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Fetal	death 3	l Ectopic p l Other <i>(sp</i> e		/			23d.	Date of delive Month	ery Day Year
CHKLICH	that the ned by a deta	by PI	Part II. Other significant conditions	contributing to death b	ut not resul	ting in the u	nderlying c	ause give	en in Part I	l.	23e. Did to	obacco use c	ontribute to th	e cause of death?
ž ť	quires en sig ould b	led I									1 🗆	Yes 2	o 3 🗆 Prob	oably 4 🗆 Unknown
FRED EHR of Vital Becords	The law reate has be page 2 sho	Completed									24a. Was autop perfo 1  Yes	osy ormed?		osy findings available impletion of cause of
_ <u>_</u>	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Othor	ce of Deat	th (Check	only one)			
<u> </u>	Phys r this eral dir	3: To	1 ☐ Yes 2 🗶 No 27. Manner of Death	1 Inpati		R/Outpatien 8b. Time of		Bc. Injury	4		ne 5 Resid			HOSPICE
n C	nding ath. r: Afte e fune	icat	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Da)	, Year)	injury	М	work?	res 2□		od. Describe i	low injury occ	dired	
Division	al or Atters after decision Director	I Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		iry - At hom	ne, farm, stre	et, factory,	office		2	28f. Location (S City or Tow		mber or Rural	Route Number,
10	the Hospit nin 24 hour the Funera npleted fills	Medical	(Check 2 Medical Example only one) 3 X Gertifying Nu	ysician: To the best of niner: On the basis of e	xamination a	and/or investi	igation, in m	ny opinior	, death oc	curred at	the time, date a	and place, and	due to the cau	ise(s) and manner stated.
ا م	Vorition Co.		29b. Signature and title of certifier	1001010			29c.	License	number	7		29d. Date sig	gned Month, E	
			30. Name and address of person who	completed cause of d	eath (Itam ?	23a) (Tiyna P	rint)	14	119	4		1/2	11 201	0.
			JACKIE JONES, CH	·			,	D.	TIMOI	NIUM.	MD 21	093		
	Sta	100	31. Date filed <i>(Month, Day, Year)</i> AUG 0 2 2010	32. Registra	r's Signatu									
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10-05519 UNK UNK Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene 2010 23937

		1- For State Certif	ficate of Death	Re	eg. No	
Physici dical Exami		1. Decedent's Name (First, Middle,Last)  Jamison Orlando Ford		2. Date of Deat Month July 23, 20	Day Year 010	3. Time of Death 2239 hrs
		4a. Facility Name (if not institution, give street and number) Good Samaritan Hospital	4b. City, Town, or Location of D Baltimore	eath	4c. County of Death	
Funeral Director	P.	5. Social Security Number 6. Sex 7. Age (In yrs. last 220-98-4218 1XM 2F 30	birthday) If Under 1 Year If Under 2  Months Days Hours	4Hrs. 8. Date of Bird Min. June	th(MM/DD/YYYY) 9. Birt 14,198) Foreig	hplace (State or n untry) MD
Aaryland 28a-f show any 1.at once.	or	Usual Residence of Decedent  10a. State	wn or Location Middle River			10d. Inside City Limits  1 Yes 2 No
the Maryland is or 28a-f sho	Director	10e. Street and Number 9902 Dehavilland Way Apt.	10f. Zip Code K 21 22 0	10	0g. Citizen of What Cour USA	ntry?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.  nut: If item 27 is marked other than "natural", or items 23a or 28a-f shu rother traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status  1 X Never Married  2 Married  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 X No	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P		White, etc.	can Indian, Black,
hours afte natural", Examiner	d by		1 Yes 2 No specify:  5a. Decedent's Usual Occupation (Give kinduring most of working life. DO NOT us		Specify: B.L.	
5-0036 iled within 72 hour Hygiene. s other than "natu the Medical Exa	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade	Driver			an Serv.
1215-( d be filed ental Hyg arked oth	Be C	17. Father's Name (First, Middle, Last) Michael V. Ford, Sr.		Name (First, Middle, M. e A. Bar	rge	7.0.1.200
MD 2 nd 2 shoul alth and M m 27 is m	To	Marie A. Ford/ Mother	9902 Dehavilland			e River,M
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 he Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ninjury or other traumatic event, the Medical E.		Cree	matory or other place) Stanislaus Cem.	7/29/10	Dundalk,	MD
Balt permit. Departs Import		21. Signature of Funeral Service Licensee	4210 Belair R	load Balt		21206
Physician /Medical Examiner		Part I. Ener the disease, or complications that caused the death. Do failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Gunshot Wounds)		liac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
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8760, tificate be ng physici as the buri	ın/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnant 1 Live birth	ncy 2 Fetal death 3 Ectopic pr	egnancy	23d. Date of delivery	ay Year
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unknown Pregnant at time of death 9 Unknown	other (Specify)			
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ital Rec iician: The s certificate irector, page	Be	25. Was case referred to medical examiner?  1 Voc. 2 No. Hospital: 1 Inpatient 2 V EF	26 Place of Death (Characteristics)	neck only one)	Residence 6 Other	
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sided in by the funeral director, page 2 should be	ion: To	1 V Yes 2 No Imparted 2 27. Manner of Death 28a. Date of Injury 280. Month Day Year)	3b. Time of Injury 28c. Injury at Work?  138 hrs 1 Yes 2 ✓ No.	28d. Describe h	now injury occurred	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Certification:	2 Accident Investigation	e, farm, street, factory, office building, etc.	or Town, S	Street and Number or Ruitate) n Blvd, Baltimore, MD	ral Route Number, City
To the Hosp within 24 ho To the Fune completely fi	Medical C	29a Certifier (Check only one) 2 Medical Examiner; On the basis of examination and/and manner stated.				
÷ ≥ 5 8	Me	29b. Signature and title of certifier	29c License number O.C.M.E.		29d. Date signed (Mor	nth, Day, Year)
OGME		30. Name and addr s f pe, so who completed cause of death (Item 23 Mary G. Ryppie Mb. Deputy Chief Medical Examir		e, MD 21201		
S	ate	31. Date filed (Worth Day Year) 32. Registar's Signature		_		

10-05594	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legi	ble.
Frederick Dean Feindt	State of Maryland / Department of Health and Mental Hygiene	20
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		- For State Registrar		Certif	ficate of	Death		, 5	Reg. No	).	20300
Physician Medical Examine	/	1. Decedent's Name (First, Middle,L Frederick Dean I	·					2. Date of De Month July 26,	eath Dav		3. Time of Death 1310 hrs
		4a. Facility Name (if not institution, 9			4	b. City, Town, o			4	c. County of Deatl	
Funeral Director	- 1	5. Social Security Number 6.	Sex 7. Age (I	In yrs. last	birthday) Yrs.	If Under 1 Ye			,	M/DD/YYYY) 9. 8ir 1951 Foreig	
ıny	-	Usual Residence of Decedent  10a. State 10b. County		c. City, To	wn or Location	on					10d. Inside City Limits
and I show a	1	Maryland Anne A		-	Burni	e					1 Yes 2 No
h the Maryland 3a or 28a-f sh otified at one	3 [	10e. Street and Number 400 Aquahart Rd.				10f. Zip Code 2 106 1	L		_	itizen of What Cou ted Stat	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	- 1	11. Marital Status  1 X Never Married 2 Marri  3 Widowed 4 Divorce	12. Was Decedent Ev Armed Forces?  1 Yes 2 X and If Yes, Give Year		If Ye		an, Mexican,	gin? ( Specify Yes or N , Puerto Rican, etc.)	No-	White, etc.	ican Indian, 8lack,
ours after a standard in a samine	<u> </u>	15. Decedent's Education (Specify	or Dates:	eted) 16	Sa. Decedent		ation (Give k	kind of work done	16b.	Kind of Business/	
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan	<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5+) 2		-	cal Sup			D	efense	
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ould be d Ments s mark tic even		19a. Informant's Name/Relationship			-	•	et and Num	ber or Rural Route N	umber, (	City or Town, State	e, Zip Code)
MD and 2 sh salth an em 27 i		Dean W. Feindt /	Brother			uahart ion (Name of c	-	Glen Burn:		MD 21061  Location - City or	Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica To Be Comple		1 Burial 2 X Cremation 4 Donation 5 Other Spec	ify:	crer	matory or other o Cren	erplace) natory,	Inc.	July 31, 2010		•	e, Maryland
Balt permit. Depart Impor injury		21. Signature of Funeral Service Lic  Scott Ruddick	per dvr		Kir   421	Crain	uddick Hwv.,	S.E., Gl	en E	Burnie, M	D 21061
Physician (Medical	1	23a. Part I. Enter the disease, or con failure. List only one cause on	each line.		not enter the	e mode of dying	g, such as ca	ardiac or respiratory a	rrest, sh	nock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ		ılar Diseas	se complica	ited by H	ypertnermia			55301
e	2	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a consequ	erine of r							
60, sate be executed physician and the burial - transit Medical Examiner		(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent)	ence of):							
760, frate be executed physician and the burial - transit	<u> </u>	UNPENDED	x AMENDED 21 p	er fl	n g906	8-3-10	vt				
		F FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkno	23c. If yes, outcome of Live birth  4 Pregnant at time		2 Feta	al death 3 er (Specify)	Ectopic	: pregnancy	20	3d. Date of deliver Month	V Day Year
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S, P.( uires that n signed ld be der	2 2	Chronic alcohol abuse									pably 4 Unknown
Division of Vital Records, P.O. Box 687 To the Hospital of Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as tedical Certification: To Be Completed by Physician	- Campus							pen 1 <b>✓</b> Yes	s an opsy formed?	prior to death?	atopsy findings available completion of cause of
/ital /sician: siccritidirector	3 4	25. Was case referred to medical examiner?  1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 EP	V/Outpatient	-	TO11	Check only one)  Nursing Home 5	Resid	lence 6 🗸 Other	r: Scene
on of Vi ending Physi ath. or: After this he funeral dir tion: To		27. Manner of Death 1 Natural 5 Pending		) F	Bb. Time of Inj OUND: 306 hrs	· I _	ury at Work?	? 28d. Describe	e how in	jury occurred	al temperatures
Division o Division o Spital or Attending sours after death. neral Director: Aft filled in by the fune Certification:	2011112	2 Accident Investig 3 Suicide 6 Could not determine	ot be 28e. Place of Injury	- At home	e, farm, street	, factory, office	building, etc	or Town,	State)	and Number or Ru	iral Route Number, City
To the Hospital within 24 hours To the Funeral completely filled		29a. Certifier 1 Certifying Phys	ician: To the best of my kr ner:On the basis of examin and manner stated.	-							
	2	29b. Signature and title of certifier	11 200				se number			Date signed (Mo. y 27, 2010	nth, Day, Year)
	3	30. Name and address of person wh Pamela E. Southall, MD	-					ore, MD 21201			
State Registra	_	31. Date filed (Month, Day, Year)	32. Registrar's		Nas 111		., Juinii			· <del></del> .	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month July Anne Marden 2010 Freeman 2:53 A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist <u>Towson</u> Baltimore If Under 1 Year Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) n. 6, 1933 1 🗆 M 2 💢 F Months Days Hours Min. Mary I and Director 77 215-32-4775 Jan. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 □ No Maryland N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 109 Fireside Circle 21212 U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🗓 No If Yes, Give þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrator Secretary year Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Jesse Marden, <u>Caroline</u> Dorothea Fischer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brice M. Freeman (son) 1108 Bellemore Road Baltimore, Maryland 21210 20a. Method of Disposition 1 ☐ Burial 2 🌡 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Green Mount Crematory 4 Donation 5 Other (Specify) 8-2-10 Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, 6500 York Road Baltimore, Mary 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Meta static Porche with Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Completed by Physician/Medical IF FEMALE yes, outcome of pregnancy
Live Birth 2 Left Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown 9 Unknown signed by t d be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 💯 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy performe death? 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 5 Pending 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Docco 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital Records,

0

Registrar's Signature

30. Vame and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certific

			Type or Print in I State of Marylan	Black I	ndelible In	k Ensure	All Copie	s Are Legik	
	•	T = For State Registrar	Otato of Marylan		rtificate of l		Worker 119	Reg. No.	0 23940
Physicia Medic		Decedent's Name (First, Middle, Last)     Lois Kost Forg					2. Date of De July 29		3. Time of Death 1:45 P M
Examin		4a. Facility Name (if not institution, give s			4b. City, Town, o	r Location of Death		4c. County of	Death
<i>}</i>		3701 International				r Spring			gomery
Funeral Director		5. Social Security Number 6. Sex 191–12–8241  Usual Residence of Decedent	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Monta/22 June 2	t <b>ub/22/1923</b> sty, Year) 3, 1923 Pe	o. Birthplace (State or Foreign Country) ennsylvania
laryland 8a-f show ified at	ector	10a. State 10b. County  Maryland Montgome		y, Town or Lo		Spring			10d. Inside City Limits 1 ☐ Yes 2 No
vith the N 23a or 28 st be not	Funeral Director	10e. Street and Number  3701 International			10f. Zip Code	. <u>3pring</u> 0906		10g. Citizen of What	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 🛣 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	- 1	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Black,	American Indian, White, etc.
2 hours a "natural" adical Ex	Completed	3 Widowed 4 Divorced  15. Decedent's Edi (Specify only highest grad	Year or Dates.	16a. Dece	dent's Usual Occup	ation	kina	Specify:  16b. Kind of Busir	White ness Industry
I within 7 ygiene. her than t, the Me		Elementary/Seconday (0-12)	College (1-4 or 5+) 4	life. E	oo NOT use retired) cher			Education	on
d be filed Mental Hy arked ott	To Be	17. Father's Name (First, Middle, Last)  Bert E. Kost					ne (First, Middle, W. Brue	, Maiden Surname) eck	
d 2 shoul alth and I 27 is ma ir trauma		19a. Informant's Name/Relationship (Typ) Glenna L. Forquer						er, City or Town, Stat Airy, Ma	e, Zip Code) aryland 21771
age 1 and int of Hea t: If item / or othe		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ F	Removal from State 20b. F	lace of Dispo emetery, cre	osition (Name of matory or other plac	ce)	Date	20c. Location - Ci	ty or Town, State
Departme Departme Mportan Iny injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	100		orial Park 2 Name and Addre 5 bert A.			Olney, Ma   Home/Roc	kville, Inc. nd 20850-2805
		23a. Part 1. Enter the disease, or compli	cations that caused the deatl						nd 20850-2805 Approximate
Physician/ Medical		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each line.  Failure t  Due to (or as a consequ		ive				Interval Between Onset and Death Years
Examiner	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	,					
executed an and rial-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequ	·					
	_	resulting in dealth East		ence oi).					
th certific ttending or use as	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of pregna 1  Live Birth 2 Feta 4 Pregnant at time of c	Ideath 3	Ectopic pregnand Other (specify)	гу		23d. Date o	
ires that the dea signed by the a Id be detached f	by P	Part II. Other significant conditions cor	tributing to death but not res	ulting in the (	underlying cause giv	ven in Part I.	23e. Did t	obacco use contribu	ite to the cause of death?
v requires s been sig should b	ted	Septicemia					1 🗆	Yes 2 ☐ No 3	Probably 4X Unknown
sician: The law re certificate has bo lirector, page 2 sh	Completed						24a. Was auto perfo	psy prio prmed? dea	re autopsy findings available or to completion of cause of th? Yes 2 \(\sum \) No
cian: ertific ector,	Be	25. Was case referred to medical examiner?	ospital:			ace of Death (Chec			
Physician: T this certifice ral director, p	은	1 ☐ Yes 2 🗶 No	1 Inpatient 2 I	ER/Outpatie		4 ☐ Nursing H		dence 6 Other (S	Specify)
Attending Pher death. ector: After the by the funeral	Certificate:	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year)	injury	M 1 🗆		Zou. Describe i	how injury occurred	
ital or A: urs after ral Direc led in by		4   Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	)			City or Tov	vn, State)	r Rural Route Number,
Hosp 4 hou Funer ted fil	edical	(Check 2 Medical Examin	cian: To the best of my knowled: On the basis of examination Practioner: To the best of my	and/or inves	tigation, in my opinio	on, death occurred a	at the time, date a	and place, and due to	the cause(s) and manner stated.
he lin 2	Me	Only One 3 to Certifying Nurse							
To the within 2 To the comple	Me	29b. Signature and little of certifier	111	B	29c. License	number		29d. Date signed (N	fonth, Day, Year)
To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completed filled in by the funeral	Σ	1 / /	M	D.	D38	e number 8457		29d. Date signed (A	

DHMH 17 Rev 7/2009

State Registrar Nakul Goyal, M.D. 3801 International Drive #211, Silver Spring, Maryland 20906

31. Date filed (Month, Day, Year)

AUG 02 2010

32. Registar's Significant

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOS Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** PUCKE# 1 □ M 2 🔀 F Months Davs Hours Min. 2-20-2010 Director 215-87-6956 Usual Residence of Decedent 10a. State 10b. County with the Maryland 10c. City. Town or Location Director or 28a-f st notified Westminster MD Carroll 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Addie Funeral 11 Hersh Ave. 21157 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Completed by 1 Never Married 2 Married Yes Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Infant Infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Jacques Gachot Nikki Puckett other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacques Gachot-father 11 Hersh Ave., Westminster, MD 21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place)
South Carroll Crem 7/30/10 Winfield, MD 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home homas E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ End-Sta Chronic Medical resulting in death) Due to (or as a consec Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Physician/Medical Examiner signed by the attending physician and d be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 24a. Was an autopsy 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of iniury Natural 5 Pending Accident Investigation 2ª Àccident 3 Suicide 4 Homicide

6 Could not be

O'Bri

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🕊 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d, Date signed (Month, Day, Year) 2401 W. BELVEDETE AVENUE Baltimore, md

23d. Date of delivery

Day

Month

23941

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between

Onset and Death

month

months

Year

1 Yes 2 X No

2010

MD Country)

14 Race - American Indian

Black, White, etc.

Specify: White

0310 AM

Medical

29a. Certifier

(Check only one)

Thomas

31. Date filed (Month, Day, AUG 1) 2 2010

29b. Signature and title of certifier

Sinai Hospital

MEdical Director 29c. License number

D0040362

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

NEWborn MEdicinE

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 State of Manyland//Separament of Health and Mental Hygiene 23942 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY 08^{ay} 2010 3:15 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A SINAI HOSPITAL OF BALTIMORE BALTIMORE Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Months Hours 01/22/1925 Director 219-12-9063 85 MD Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if items 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21208 USA 4001 OLD COURT ROAD, #201 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) EXECUTIVE WHOLESALE DISTRIBUTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **GREENEBAUM** SARAH WINER MILTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4001 OLD COURT ROAD, #201, BALTIMORE, MD MARJORIE GREENEBAUM/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) 7/9/2010 OWINGS MILLS, MD HAR SINAI CEMETERY Signature of Juneral Service Lice and Address of Facility SOL LEVINSON & BROS REISTERSTOWN ROAD, PIKESVILLE, INC. 21208 8900 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. ne death. Do not enter the mode of dving. Interval Between Immediate Cause (Final and Death Physician/ disease or condition Medical resulting in death) (or as a consequence of): Examiner CAL EXAMINE Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of) if any, reading to immediate cause. Enter Underlying been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last PPROVED BY Due to (or as a consequence of) Division of Vital Recofds, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe after death.

Director: After this certificate 2 🗆 No Yes 20 No completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Simpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

3 0 2010

ompleted cause of death (Item 20a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ GORDAN Month DIANE 10:45 AM JUNE 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY ROCKVILLE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours (Month, Day, Year Oct 26, 1 □ M 2 🛱 F unk Director 48 223-13-1727 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 USA 9701 Medical Center Drive unk 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 🔯 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 ▼ No Specify: white Specify: "natural", 3 Divorced 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) unk unk disabled none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 slr Department of Health au Important: If item 27 is any injury or other trau Shady Grove Adventist Hospital 19901 Medical Center Drive Rockville, MD 20850 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in state 21. Signature of Fundal, ervice Liveral e1 ^{22. Name and Address of Facility}Board 655 W. Baltimore Street Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COMPLICATIONS OF REMOTE DRUG INTOXICATION Physician/ YEARS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner MULTI ORGAN FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) THE CHICAL STANDER -transit Hospital or Attending Physician: The law requires that the death certificate be executed SHOCK SEPTIC and Due to (or as a consequence of): resulting in death) Last burial-1 attending physician for use as the buria Physician/Medical PNEUMONIA ASPIRATION Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by STAGE IN DECUBITUS ULCER 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of URINARY TRACT INFECTION 24a. Was an certificate has autopsy page death? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital: 1 X Yes 2 No မ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred
FOUND UNRESPONSIVE AFTER injury work? 1 ☐ Yes 2 🕱 No ☐ Natural 5 Pending nours after death.

neral Director, Aft
filled in by the fur MARCH 7 2007 22:00 M INGESTION OF NEW SLEEP MEDICATION 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, determined 217 SPRING AVE within 24 hours a

To the Funeral D

completed filled i HOME ROCKVILLE Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JUNE 25 2010 Machan Hulbin MD D0062562 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

MADHAVI HUBBLY MD

AUG <u>0 2 2010</u>

31. Date filed (Month, Day, Year)

9901 MEDICAL CENTER DR

32. Registrar's Signature

20850

MD

ROCKVILLE

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					, ,		2391.1.
	Dharisis	/	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
p	Physicia Medio	cal		T	JULY		1:00 AM
-	Examin	ier		State of Maryland / Department of Health and Mental Hygiene  Certificate of Death Res., N. O. D. 2.3944  Last Last Last Last Last Last Last Las			
H	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign
	Director		210 40 1772 00 ms.	Certificate of Death  Reg. No. 2   1   2   3   4    S. Trins of Death  Reg. No. 2   1   2   3   4    S. Trins of Death  Reg. No. 2   1   2   3   4    S. Trins of Death  Reg. No. 2   1   2   3   4    S. Trins of Death  Reg. No. 2   1   2   3   4    S. Trins of Death  Reg. No. 2   1   2   3   4    S. Trins of Death  Reg. No. 2   1   2   3    S. Trins of Death  Reg. No. 2   1   2   3    S. Trins of Death  Reg. No. 2   1   2   3    S. Trins of Death  Reg. No. 2   2   2    S. Trins of Death  Reg. No. 2   2   2    S. Trins of Death  Reg. No. 2   2   2    S. Trins of Death  Reg. No. 2   2   2    S. Trins of Death  Reg. No. 2   2   2    S. Trins of Death  Reg. No. 2   2   2    S. Trins of Death  Reg. No. 2   2   2    S. Trins of Death  Reg. No. 2   2   2    S. Trins of Death  Reg. No. 2   2   2    S. Trins of Death  Reg. No. 2   2   2    S. Trins of Death  Reg. No. 2   2   2    S. Trins of Death  Reg. No. 2   2   2    S. Trins of Death  Reg. No. 2   2   2    S. Trins of Death  Reg. No. 2   2   2    S. Trins of Death  Reg. No. 2   2   2    S. Trins of Death  Reg. No. 2   2   2    S. Trins of Death  Reg. No. 2   2   2    S. Trins of Death  Reg. No. 2   2   2    S. Trins of Death  Reg. No. 2   2   2    S. Trins of Death  Reg. No. 2   2   2    S. Trins of Death  Reg. No. 2   2    S. Trins of Death  Reg. No. 2   2    S. Trins of Death  Reg. No. 2   2    S. Trins of Death  Reg. No. 2   2    S. Trins of Death  Reg. No. 2   2    S. Trins of Death  Reg. No. 2   2    S. Trins of Death  Reg. No. 2   2    S. Trins of Death  Reg. No. 2   2    S. Trins of Death  Reg. No. 2   2    S. Trins of Death  Reg. No. 2   2    S. Trins of Death  Reg. No. 2   2    S. Trins of Death  Reg. No. 2   2    S. Trins of Death  Reg. No. 2   2    S. Trins of Death  Reg. No. 2   2    S. Trins of Death  Reg. No. 2   2    S. Trins of Death  Reg. No. 2   2    S. Trins of Death  Reg. No. 2   2    S. Trins of Death  Reg. No. 2   2    S. Trins of Death  Reg. No. 2   2    S. Trins of Death  Reg. No. 2   2    S. Trins of Death  Reg. No. 2   2    S. Trins of Death			
	and show lat	٥		cation			10d. Inside City Limits
	Maryla 28a-f otified	rect	MD Anne Arundel Pasade	na			1 ☐ Yes 2 🔀 No
	th the	<b>Funeral Director</b>	10e. Street and Number	II.	10g	. Citizen of What Co	untry?
	ath wi ems 2 r mus	nue	630 Dover RD  11. Marital Status  12. Was Decedent Ever in U.S. 13. 13. 13. 13. 13. 13. 13. 13. 13. 13		cify Yes or No-		
ဖွ	ter de , or ite	by F	Armed Forces?  1 □ Never Married 2 🗷 Married 1 □ Yes 2 🛣 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	e, etc.
8	ours af tural" al Exa	ted	3 🗆 Wildowed 4 🗀 Divorced Year or Dates.			Specify: W	nite
75	72 hc In "na Medic	Completed	(Specify only highest grade completed) (Give	kind of work done during most of worki	ng 16t	b. Kind of Business	Industry
212	within giene. er tha , the I		Elementary/Seconday (0-12) College (1-4 or 5+)			Real Est	ate
pu	e filed Ital Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)		, ,		
78	d Mer d Mer marke matic	-					
Σ	12 sho alth an 27 is r trau		Too main				
ore,	of Hez of Hez fitem		20a. Method of Disposition 20b. Place of Dispo	sition (Name of			
<u>Ë</u>	Page ment tant: I		4 □ Donation 5 □ Other (Specify) Bayview	Crematory 7/2			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	. Name and Address of Facility GJ	Gonce F	uneral	Home, PA
				169 Kiviera Dr	<u> Pasader</u>	na, MD	21122
	h sician/		shock, or heart failure. List only one cause on each line.			ENT	Interval Between
	Medical Examiner		disease or condition resulting in death)  a. Due to (or as a consequence of):	*	Main	10 1	
		r e	Sequentially list conditions, D.	fibrilation			
-	ed nsit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury				
	be executed sician and burial-transi		that initiated events C				
9	r requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical	<b>L</b> d				
687	ertifica ding p	Physician/Medi	IF FEMALE: 23c If yes outcome of pregnancy				
ŏ	atten atten	ician	in the past 12 months?				*
В	the de by the achec	hys	9 □ Unknown 9 □ Unknown				
Division of Vital Records, P.O. Box 6876	The law requires that the death certificate are has been signed by the attending physpage 2 should be detached for use as the	by		nderlying cause given in Part I.			
rds	require been s hould	Completed by					
ပ္ပ	e law e has l ige 2 s	dmc			autopsy performed	prior to c	ompletion of cause of
<u>e</u>	an: Th tificat tor, pa	Be C	25. Was case referred to medical	26. Place of Death (Check		No 1 ☐ Yes	2 1/2 No
Z Z	hysici his cer Il direc	유	1 Inpatient 2 ER/Outpatien	Other		6 ☐ Other (Speci	fy)
ļ U	ding P h. After t funera	Certificate:	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury	work?	8d. Describe how in	jury occurred	
SIO	Attengradus death	≝	3 Suicide 6 Could not be 380 Place of Injury - At home form eter		P8f. Location (Street	and Number or Run	al Route Number
2	tal or rs afte al Dire ed in t		building, etc. (Specify)				a risate riamber,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director After this certificate has a completed filled in by the funeral director, page 2 s	Medical	29a. Certifier 1	ccured at the time, date and place, and igation, in my opinion, death occurred at	d due to the cause(s)	and manner as sta	ted. ause(s) and manner stated.
	o the	ž	only one) 3 L Certifying Nurse Practioner: To the best of my knowledge, d	eath occurred at the time, date and place	e, and due to the caus	se(s) and manner as s Date signed (Month)	stated.
	-> <b>-</b> 0				250.1	July 25th	, 2010
j	41		30. Name and address of person who completed cause of death (Item 23a) (Type, P Kulpesh Patel, M) Baltimone Was hing	int) Medical Center	, 301 Host	nital Drive	e, Glen Burnie
	State Registra	е	31. Date filed (Month, Day, Year)  AUG 0 2 2010  32 Registrar's Signature			/	FN 4010/
			TOU UN LUIU DONNE P. MICE				

GALTORD, LINDA L.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 1 per doc 9906 8-5-10 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Elmer Allan Horsey 7^{Month} Physician/ 28^{Day} 2010 1755 Allen Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Ctr Glen Burnie Anne Arundel . Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days 1 😿 M 2 🗆 F 215-30-4408 78 7-18-1932 Director MD Usual Residence of Decedent or 28a-f shov 10a, State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director Anne Arundel Glen Burnie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 231 Margate Drive 21060 USA Page 1 and 2 should be filed within 72 hours after death w ment of Health and Mental Hygiene. Iant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 ☐ Never Married 2 🖫 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Plumbing Supply Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ William Thomas Horsey Sr. Clara Mary Trimper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra Barbara R. Horsey/wife 231 Margate Drive, Glen Burnie MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of F Important: If ite any injury or ot once. Date cemetery, crematory or other place, Metro Crematory 1 Burial 2 X Cremation 3 Removal from State 8/2/2010 4 Donation 5 Dather (Specify Catonsville, MD 22. Name and Address of Facility Kirkley-Ruddick Funeral Home P.A. M01364 421 Crain Hwy SE Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a co is quence of) Examiner Sequentially list conditions, Examiner Due to (of as a consequence of) if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No ρ Month Day Year within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it 1 L Yes 2 L g Unknown Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? rovacular 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Tes 2 D No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PASADENA MD 21122 2. V. CYRIAC .M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 26,27,29a per dr.,2906,08/02/2010dhb

Certificate of Death

Reg. No. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Month 04:54 AM Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 40 HIMOre If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day 1 □ M 2 💢 F 3 Months Min Yrs. Director Usual Residence of Decedent "natural", or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any nigry or other traumatic event, the Medical Examiner must be notified at any nigry or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 🗆 Yes 2 XNo HIMOre 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Kaga USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ₩idowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) Mailing *aughter* 160 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Sio ature of Funeral Service icen -Marylung 23a. Part / Enter the lisease, or complications that caused the death. Do not enter the mode of dying, show, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Small Bowel obstruction disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or iinjury sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director: After this certificate it 1 🗌 Yes 2 No Yes completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 🔽 No Other: Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🚨 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗶 Natural 5 Pending injury work? 2 🗌 No Investigation Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 only one Certifying Nurse Practioner: To st of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29h. Signature and title of certifier 29d, Date signed (Month, Day, Year) 7125110 D0070435

Stat

State Registrar avra Patel

31. Date filed (Month, Day, Year)

BRIK

Baltimove, MD

21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2

charles

Registrar's

6701

AUG 0 2 2010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JULY 20 2010 CELESTE HERMAN Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 2015 BEAR RIDGE RD. BALTIMORE APT. DUNDALK 8. Date of Birth (Month, Day, Year) AUG. 22, 1963 Social Security Number 6. Sex 1 ☐ M 2 😿 F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Birthpica Country) MD **Funeral** Hours Director 220-88-2311 46 Usual Residence of Decedent show 10b. County at 10a. State 10c. City, Town or Location 10d Inside City Limits should be filed within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s 1 🔀 Yes 2 🗌 No MD BALTIMORE DUNDALK 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2015 BEAR RIDGE RD. - APT. #103 21222 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. Completed by ☐ Yes 2 🔀 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 🖾 No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. Iant: If item 27 is marked other than "natur jury or other traumatic event, the Medical." 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) **FACTORY** 12TH LABORER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MICHAEL HERMAN ELIZABETH MAJAWSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA MEKINSKI/SISTER TIMBER TRAIL, BELAIR, MD 21214 206-D 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 07/23/2010 | HANOVER, MD ARDENT 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WESLEY CHAVIS, JR. FINRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part 1. Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) notastache Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should he detached for use as the burneral director, page 2 should he detached for use as the burneral director. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No Division of Vital Records, 1 🔲 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼No 24a Was an autopsy performed Yes 2 25. Was case referred to medical Be ( 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 
Yes 28d. Describe how injury occurred 5 Pending iniury 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOS76136 225. Greene St. Baitimure MD 21201. 30. Name and address of person who completed cause of death (Item 23a), (Type, Print) 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For Amend 1	tem 2	5 State of me	Manylar ,ecoeg	67/ <b>367</b> Cer	2010ah 8 ^{f l} tificate of l	Health a Death	nd Mental Hy	/giene Reg. N2010	23948
	-		1. Decedent's Name (First	t, Middle, La	st)					2. Date of D	eath	3. Time of Death
	Physicia Medic		Cerise M	ionae	Hendr	ick				July	19, 2010	2:04 A M
	Examir		4a. Facility Name (if not in			· ·		4b. City, Town, c			4c. County of D	
			Southern					Clin			PG	
	Funeral Director		<ol> <li>Social Security Number</li> <li>216-37-265</li> </ol>		Sex 7	. Age (In yrs. 17	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, D	ay, Year)	Birthplace (State or Foreign Country) arvland
	ow t		Usual Residence of Deced	dent County		40- 0	ty, Town or Lo			10,50	,,,,,	
	arylan a-f sh fied a	Director	MD Tob.	PG		100.01	Clint					10d. Inside City Limits 1X Yes 2 □ No
	or 28	<del> </del>	10e. Street and Number					10f. Zip Code			10g. Citizen of What	
	with til 23a c	-ia	11609 Zare	eh Dr	ive				735		USA	Country
	eath v	Funeral	11. Marital Status		12. Was Decede		S. 13. \	Vas Decedent of H	lispanic Origin	n? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - A	merican Indian,
98	fter d	ð	1 X Never Married 2	☐ Married	Armed Force					Puerto Rican, etc.)	Black, W	hite, etc.
8	rurs a tural' al Ex	ted	3 Widowed 4 D		If Yes, Give Year or Date	es.		☐ Yes 2XXNo			Specify: B	lack
15-	72 ho n "na 1edic	Completed	(Specify or		ducation ade completed)		(Give i	ent's Usual Occup	during most o	f working	16b. Kind of Busine	ss Industry
212	vithin iene. rr thau		Elementary/Seconday 12th	(0-12)	College (1-4	or 5+)		O NOT use retired) tudent			Educa	tion
ρ	filed val Hyg	Be	17. Father's Name (First, A	Middle, Last)					18. Mother'	s Name (First, Middle	, Maiden Surname)	-
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	욘	Wilhelm	F. H	endrick	, Sr.			I	∟eAnn Wil	lliams	
/ar	shou and is m	19	19a. Informant's Name/Re								er, City or Town, State,	Zip Code)
	and 2 Health em 27		LeAnn C. Her 20a. Method of Disposition		/ Mother				rive;	Clinton, N		
Jo.	ige 1 nt of 1 t: If it	ı	1√XBurial 2 ☐ Cre	mation 3	Removal from S	tate (	cemetery, cren	sition (Name of natory or other place	ce)	Date	20c. Location - City	
Baltimore,	nit. Pa artme ortan injury	ľ	4 Donation 5 21. Signature of Juneral S			Re		tion Cem		7/24/2010		
Ba	permir Depar Impor any in	3	▶ alena	an	freer	war,	4	594 Beec	h Road	; Temple H	neral Serv Hills, MD	20748
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	Medical Examiner		resulting in death)	ſ		as a conseq	,					
		Jer	Sequentially list condition	s,	b. Durate (or	98 9 PS(189Q	Hence of	ISORDA	<u>-</u> P		11/	
1118	d uted	dical Examine	cause. Enter Underlying Cause (Disease or iinjury that initiated events	5					(	Janos de Medical.	CERTIFICATION	
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×××	ath ce attenc for us	sian	23b. Was decedent pregna in the past 12 months				al death 3	Ectopic pregnand Other (specify)	у		23d. Date of of Month	delivery Day Year
NA	y the c	Physician/Me	1 Yes 2X No		9 Unknov		death 5	Other (specify)				
) O.	Attending Physician: The law requires that the death rr death. sctor: Affer this certificate has been signed by the atte by the funeral director, page 2 should be detached for		Part II. Other significant of	conditions c	ontributing to dea	th but not res	sulting in the u	nderlying cause giv	/en in Part I.	23e. Did 1	tobacco use contribute	to the cause of death?
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Records, P.	aw rec as be 2 sho	Completed by	PER CUITA	MEVU	S GAST	RUST	um B	UTTO P.		24a. Was		autopsy findings available o completion of cause of
Re	The la	Con								perfe	ormed? death	
Ta Z	ician: sertific ector,	Be	25. Was case referred to mexaminer?		Hospital:					(Check only one)		
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0 0	nding th. t After t fune	cate	<b>-</b> 0	Pending Investigation	(Month,	Day, Year)	injury	work			how injury occurred	
Division of Vita	er des ector by th	Certificate:		Could not b	e 28e. Place of	Injury - At ho	me, farm, stre	et, factory, office			Street and Number or F	Rural Route Number,
Ω̈́	ital or urs afte ral Dire				Building,	, etc. (Specify	" —————————			City or Tov	wn, State)	
(1)	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 / Me	dical Exami	iner: On the basis	of examination	n and/or investi	gation, in my opinio	n, death occu	irred at the time, date	ause(s) and manner as a and place, and due to the se cauca(e) and manner	e cause(s) and manner stated.
9	To t		29b. Signature and title of		*			29c. License			29d. Date signed (Mor	nth, Day, Year)
			30. Name and address of p	1-1	L'ALA	MD		150	689		07 20	2010
			30. Name and address of p	person who	completed cause	of death (Item	1 23a) (Type, Pi	int) ANI	LICA	PARAJA	NO MON SU	HTHERN N 3022
	Stat	e	31. Date filed (Month, Day,	Year)	Regi	istrar's Signat	10 L	N. J	+11 es	KUND (L	The MAN	D 20735
	Registra	r	JUL:	3 U 201	U Clerk	m p	1. 400	Ver				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Houser 2010 7:32 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore of Maryland Medical Cont University 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth Dec 3, 1932 **Funeral** 9. Birthplace (State or Foreign M 2 □ F Days Hours Min. **Director** Pennsylvania 182-30-2605 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No MD Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21223 USA 208 S. Vincent Street 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) United Iron & Metal crain operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Irvin Earl Houser Martha Jane Achins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Houser - wife 208 S. Vincent Street; Baltimore, Maryland 21223 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place 22. Name and Address of Facility State Anatomy Board Signature Range Sice Wade Director 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ Ischemic Colitis Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or immediate) Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. attending physician and for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year signed by the a ld be detached f g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed Artery Discase has been sign e 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Ob structive discuse 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No s certificate ha lirector, page death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗷 No Other: မြ 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No neral Director; A □ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C Medical 29a. Certifier 1 **Exertifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifler 29c, License number 29d, Date signed (Month, Day, Year) D22247 MD 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Jason Ol

31. Date filed (Month, Day, Year)

South

32. Registrar's Signature

Greene

Sweet

Bultimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend Items 4a,b,c,13 per dr/fn,g906,08/02/2010dhb Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1:00PM angs 2010 Medical 4a. Facility Name (if not institution, give street and number, 7019 Surrey Drive Examiner 4b. City, Town, or Location of Death 4c. County of Death altinone Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 1 №M 2 □ F Months Hours Min. (Month, Day, Year) Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Battimore, 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 USA Surrey Drive rmed Forces?

Yes 2 No
Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 No 2 No If Yes, Give Year or Dates Specify: Specify: Back Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare Orderl Hyears 12th wade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) laence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Baltimore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date, ☐ Burial 2 Cremation 3 ☐ Removal from State Treenmount Crematory 07/29/10 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Addres Facility 21. Signature of Funeral Service Licensee Jaughn C. Greene Funeral services Road Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a onsequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit been signed by the attending physician and should be detached for use as the burial-transit NA that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical SCON #イタス Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has b autopsy performe death? 24 hours after death.

Funeral Director: After this certificate leted filled in by the funeral director, pag 2 🗌 No 1 🗌 Yes Yes e e 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Other: ည 2 ₽∕No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes 2 🗌 No Investigation Accident Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) wilke 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) de AI AWRNY 31. Date filed (Month, Day, Year) 32. Registrar's Signature

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Papartment of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20/0 MATH OHAMMED 17:24 PM , Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ARYNZEI Baltimore Washington Medical Center BURNIC Anne Glew If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 7. Age (In yrs, last birthday) Yrs. 6. Sex 1 🗶 M 2 🗆 F 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director Usual Residence of Decedent Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PrINCE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral NDI 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Completed by 1 Yes Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🛣 No Specify: NOUaN 3 🗆 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) MOHAMMED Elementary/Seconday (0-12) College (1-4 or 5+) ABOR GOVERNMENT Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surnam FIDDI 20774 19a, Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TON PKNY, Upper Marlbors, TURNER Mohamme WOOT Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date KHAN. 1 A Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Mary Land Nationa 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 10220 (rui Hori) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 80mc disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) EXAMINER or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury ON APPROVED BY MEDI and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) 4 Pregnant 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital ပ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending Accident Investigation 24 hours after deatl Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) the Hospital Medical 🔭 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Configure Nurse Practioner To the cost of my knowledge, death occurred at the time, date and place, and the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29d. Date signed (Month. Day. Year) MAT mances Name and address of person who completed cause of death (Item 23a) (Type, Print) RANCIS Baltimore Washington Melical Contect Mo 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 30 Registrar

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		1	State of Ma State Amend Item 26 per ver Registrar	aryland / Depa <b>b., g906,08</b>	artment of F 702/2010d tificate of I	lealth and Menta <b>hb</b> <i>Death</i>	al Hygien Reg. N	2010	23952
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94	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	4	c. County of Death	
,	Funeral Director		1 <b>X</b> M 2 □ F	e (In yrs. last birthday) 73 Yrs.	Havre If Under 1 Year Months Days	de Grace If Under 24 Hrs. 8. Dan Hours Min. 02 //	te of Birth Porth, Day, Yea 24/193	以   Coui	place (State or Foreign ntry)
	0		207–28–9161 Usual Residence of Decedent	, ,		027	21, 193	, Leini	sylvania
	arylar show	'n	10a. State 10b. County	10c. City, Town or Lo	cation			1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the N 28a-f	Director	Maryland Harford  10e. Street and Number	Aber	deen  10f. Zip Code		10g. (	Citizen of What Cour	
	th with	a D	357 Walker Street		210	01	USZ	Δ	
Maryland 21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show ficel Exa. Incr. ust be retified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent E Armed Forces?  14 □ Yes 2 □ Yes 2 □ Year or Dates:	10 1334-		ispanic Origin? (Specify Yen, Mexican, Puerto Rican, Specify:		14. Race - Americ Black, White, Specify: whi	etc.
15-0	hin 72 hc e. <b>an "natu</b> l Medical	letec	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup kind of work done o	ation during most of working ')	16b.	Kind of Business/In	dustry
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pu	be filed ntal Hygi ed other event, I	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name (First,			
ýlai	should be and Mental smarked o	은	Richard O. C. Kramp			Bertha L. F			
Mar	d 2 th (7 in tra		19a. Informant's Name/Relationship (Type. Print)			and Number or Rural Route	,		Code)
ē,	s 1 and 2 of Health item 27 i		Carole Kramp (wife)  20a. Method of Disposition	20b. Place of Dispo		., Aberdeen,		Location - City or To	own, State
imo	nit. Page: bartment o ortant: If injury or		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)			ardens 7/28/	10 Abe	erdeen, Ma	aryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.	yr (1	21. Signature of Funeral Service Licensee	nha.	2. Name and Address berdeen,	ss of Facility Tarrin Maryland 210	g_Cargo 01	o Funeral	Home, P.A.
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not ent	er the mode of dyin	g, such as cardiac or respi	ratory arrest,		Approximate Interval Between Onset and Death
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44	po tis	iner	cause. Enter Underlying	a consequence of):	- 1	0.30			
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Division of Vital Records,	30	Completed				1[	a. Was an autopsy performed? Yes 2 4	prior to co death?	psy findings available impletion of cause of
Z.	ysicial is certi directo	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 □ No Hospital: 1 □ Inpatie	nt 2 ER/Outpatien	t 3 DOA Othe	26. Place of Death (Chec er: 4 ☐ Nursing Home 5		6 ☐ Other (Specia	6.1
n of	ding Phy J. After thi funeral o	n.	27. Mann of Death  1 Natural 5 Pending (Month, Day	ry 28b. Time of			escribe how inj		) 
siol	Attending Physician: It death. ector: After this certific by the funeral director,	catic	2 Accident Investigation		M 1 □	Yes 2□No			
Divi	al or Atten after death Director: d in by the	Certification: To	4 Homicide determined 28e. Place of Injurial building, etc.	rry - At home, farm, stre c. (Specify)	eet, factory, office		cation (Street a by or Town, Sta	and Number or Run ate)	al Route Number,
	On the Hospital or Attending Physician: within 24 hours after death within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of and manner sta	examination and/or in	n occurred at the tin vestigation, in my o	ne, date and place, and du pinion, death occurred at th	e to the cause ne time, date a	e(s) and manner as s and place, and due t	stated. o the cause(s)
	To the H within 24 To the Fi	M	29b. Signature and title of certifier  May Bernaddt	e nortelle	29c, License	056091	29d. [	Date signed (Month,	Day, Year)
V	ナソ		30. Name and address of person who completed cause of de SIMA ALTH M	eath (Item 23a) (Type, I	Print)				
	Stal Registra	_	31. Date filed (Month, Day, Year)  AUG 0 2 2010  AUG 0 2 2010	ar's Signature	lad				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19b, perfit, G906, 8/2/2100, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Deat Physician/ Medical ∡Æxaminer 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death easons Hospice eNW Randallstown Baltimore HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, Year | 19 | 19 | 19 | 19 | 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 D F 217.68.4675 MD Director Usual Residence of Decedent 28a-f shov 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Examiner must be notified at Funeral Director MD Baltimore 1 Yes 2 No 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5019 Arbutus Avenue 21215 LISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Berman's 12th grade ruck Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Fin Lawrence, Jr. VIISELLA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3909 W. Garrison to Ave. Baltimone, MD 21215 Drusella Lawrence 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Denial 2 Cremation 3 Removal from State cemetery, crematory or other place) 2010 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) cemeters 06 Vallyho C. Greene Funeral Sarvices 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1 west Head andallstown, MD 21133 23a. Part 1. Eiger the disease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest shock, or leart failure. List only one cause on each line. Approximate Interval Between Immediate Caus II inal Onset and Death Physician/ disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter University Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Certificate: To Be Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Month Year 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 🗎 No 3 🗖 Probably 🥍 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🔲 No 1 Tyes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin ca 180 F 31. Date filed (Month, Day, Year) State AUG Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2010

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Owner OW ron 3:45p Jul 27, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3926 Duval Avenue Baltimore N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Min 1 ☐ M 2 ☐ F Months Days Hours Director 114-32-8725 67 Aug 11, 1942 Georgia Usual Resid 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show other traumatic event, the Medical Exeminer must be notified at 1 ¥ Yes 2 No Director **Baltimore** 28a-f Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 3926 Duval Avenue 21216 U.S.A. Funeral or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 196 14. Race - American Indian. Black, White, etc. after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify <u>ک</u> 1967 Specify. 72 hours 3 Widowed 4 Divorced Year or Dates: Black "natural" 1097 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army Military marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fill and Mental h Be ဂ္ဂ Rosezena Dunn **Emanuel Lawrence** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sl ment of Health an ant; If Item 27 Is 3926 Duval Avenue' Baltimore, Maryland 21216 Dorothy Lawrence 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1
Department of I
Important; If Ite
any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/03/10 Pikesville, Maryland **Druid Ridge Cemetery** 22. Name and Address of Facility 21. Signature of runeral Service Licensee Estep Brothers Funeral Service. P. A 1300 Eutaw Place Baltimore, Md 21217
Do not enter the mode of dying, such as cardiac or respiratory arrest. 23a. Part 1. Enter the disease, or complications that caused the death. shack, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 7-4ears disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of executed and Due to (or as a consequence of) Box 68760 attending physician for use as the buria that the death certificate be Physician/Medical the as yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2 No o. 9 Unknown ٣. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 🗌 Yes 2. No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital or Attending Physician: The law 24a. Was an has page 2 s autopsy certificate 2 🗆 No 1 ☐ Yes 2 No 1 ☐ Yes director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending s after decreal Director: A in by the 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in I within 24 hours a

To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0042593 110 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers 111) 21201 Q4 South ree 31. Date filed (Month, Day, Year) 32. Renismar's Signature State Registrar

	30. Name and address of person who co	CEU OTRAD						7.0	₹U. 02	
Ž	29b. Signature and title of cerifier	Rev SNUD  mpleted cause of death (Item ) MD 126 1  32. Registrar's Signa		29c. L	icense number	322	2	9d. Date sig	oned (Mont)	n, Day, Year)
Medical	(Check only 2 Medical Examination one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	tion and/or in	vestigation, in	my opinion, de	eath occurre	ed at the time, da	ate and plac	ce, and due	s stated. to the cause(s)
Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	v)	eet, factory, o	ffice	2	8f. Location (St. City or Town	n, State)		
tion:	27. Manner of Death  1	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	M 28c	Injury at Work? 1 □ Yes 2 □	_	8d. Describe ho	ow injury occ	curred	
은	I les Ze No	ospital: 1   Inpatient 2			Other: 4 🗆 N	lursing Hom	ne 5 Reside	ence 6 🗆		cify)
Be Co	25. Was case referred to medical				26. Plac	e of Death	perform 1 □ Yes 2 (Check only one		1 □ Yes	2 □No
Completed							24a. Was ar autops perforn	V	prior to death?	topsy findings a completion of ca
	-						1 □ Ye	s 2 No	o 3□ Pr	obably 4
by Ph	Part II. Other significant conditions cor	stributing to death but not resu	ulting in the ur	nderlying caus	se given in Part	1.	23e. Did tob	acco use c	ontribute to	the cause of de
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3 □	Ectopic prec					Date of del Month	ivery Day Y
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	Carrie Sweitzer 20a. Method of Disposition					Apt B	Elktor	n, Mar 20c. Locatio		
은	19a. Informant's Name/Relationship (Ty	pe. Print)	1	-	treet and Numl	ber or Rural	Route Number,	; City or To		
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Completed	Elementary/Secondary (0-12) unk	College (1-4or 5+) unk	me. L	JO NOT USE!						
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p	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates:		1 □ Yes 2 🏖			,/		cify: Wh	
Funeral	164 W. Main Stre	et; Apt B  12. Was Decedent Ever in U. Armed Forces?	S. 13. \	Was Deceden	t of Hispanic O Cuban, Mexica	rigin? (Spe	cify Yes or No-			rican Indian,
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	Usual Residence of Decedent  10a. State 10b. County	I	y, Town or Lo	cation						10d. Inside Cit
al or	5. Social Security Number 6. Security Number 221–44–1671	7. Age (In yrs. 1) M 2 1 52		If Under 1 Months E	Year If Unde Days Hours	Min.	8. Date of Birth (Month, Day, Feb 26,	Year) 1958	, Co	nplace (State or untry) y land
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cian dical	Margaret Littleto  4a. Facility Name (If not institution, give			4b City To	wn, or Location	of Death	July	Day 7	2010 nty of Deatl	07:40
							<ol><li>Date of Deatl Month</li></ol>		Year	3. Time of I

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AMEND ITEM#30perDVR, G906/8/2/2010, WS
State of Maryland / Department of Health and Mental Hygiene 23956 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death O Month Physician/ HELEN D. LACHER 20 jear 22 5:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8411 Bussenius Rd. Pasadena Anne Arundel If Under 1 Year If Under Funeral Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🏋 F Days Months Hours Min. Country) Director 212 30 5779 77 Usual Residence of Decedent 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Anne Arundel Pasadena ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8411 Bussenius Rd 21122 "natural", or items Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗷 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates permit, Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Bertha Dec John Macioch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8411 Bussenius Rd Pasadena, MD 21122 Kathleen Starks - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 7/26/10 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Pk Glen Burnie, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Home, GJ Gonce Funeral Riviera Pasadena, MD 21122 Dr23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ 194 otsubo cardiohyono disease or condition Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause, Enter Underlying the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ੬ 1 Yes 2 No 3 Probably 4 Unknown Completed been Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy After this certificate 1 Yes 2 No I ☐ Yes 2 Links 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Certificate: To Other: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29d. Date signed (Month, Day, Year) mo 23 2010 Magothy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sutt Zaft My Pasadena Maryland

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23957 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 26°, 20 Î Margaret Mae 3:25  $P^{M}$ Loveless July Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. (Month, Day, Year) av 4, 1928 Pennsylvania **Director** 196-22-8251 82 May Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 🏻 No Maryland Montgomery Bethesda 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 7010 Pyle Road 20817 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 0 Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes : 2 💢 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: "natural" Specify: 3 X Widowed 4 □ Divorced White Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natur ury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carl Dutzman Elizabeth Petroczy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa M. Stella / Niece 840 West Glebe Road, Alexandria, Virginia 22305 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 
Burial 2 
Cremation 3 
Removal from State Department of Important: If any injury or Montgomery Crematorium, Inc August 1, 2010 4 Donation 5 Other (Specify) Bethesda, Maryland 21. Sign to of Funeral Service Usensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph. sician/ disease or condition resulting in death) Ventricular Fibrillation Medical Due to (or as a consequence of) Examiner Acute Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, attending physician and for use as the burial-transi Coronary Artery Disease that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Congestive Heart Disease that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant 9 Unknown Year Pregnant at time of death 5 Other (specify) Month Day signed by the a 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ischemic Cardiomyopathy, Pneumonia r Attending Physician: The law requires Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No 24a. Was an performed? Yes 2 X No 25. Was case referred to medical examiner? Be of Vital 26. Place of Death (Check only one) 1 ☐ Yes 2 🛣 No Other: မြ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred X Natural injury 5 Pending Division To the Hospital or Attencial within 24 hours after death. To the Funeral Director: A. Accident
Suicide
Homicide death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Cerlifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated at Control of Nurse Frantism of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29c. License number 29d. Date signed (Month, Day, Year) D53691 July 27, 2010 who completed cause of death (Item 23a) (Type, Print) 3200 Tower Oaks Blvd., Rockville, Maryland 20852 M.D.

State Registrar

oveless

32. Registrer's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/  $\stackrel{\mathsf{Month}}{\mathsf{JULY}}$ 28 Day MANUEL 2010 3:10 P M LEVIN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 Months Days Hours 1072571909 **Director** 220-44-4804 100 Usual Residence of Decedent f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 🏋 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1840 REISTERSTOWN ROAD, #303 21208 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. ò 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. WHITE Specify: "natural" Completed 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) PHYSICIAN MEDICINE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JACOB LEVIN REBECCA DIENER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARCIA MILIMAN/DAUGHTER 3417 TERRAPIN ROAD, BALTIMORE, 20a. Method of Disposition 20b. PIROR RICHTSTRY Warne of cemetery, crematory of other place 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State BENEFICIAL CIRCLE 7/30/2010 BALTIMORE, MD Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if at y, each got in rediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consectioned on Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death 2 🗌 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown this certificate has been signed by ral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to edical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No မြ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Director 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, usual occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29d. Date signed (Month, Day, Year)

TUY 79, 20/6 29b. Signature and 29c. License number 053850

Registrar
DHMH 17 Rev 7/2009

State

Northwest Hospital

Center Stolold Coxt Rd Randows MD

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. NZ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FERNE LITFIN 09:45 AM TUL 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY OFMARYLAND MEDICAL CENTER N/A BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F 76 Hours Min 10/05/1933 Country) 220-52-4588 Director MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c, City, Town or Location 10d Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director **BALTIMORE BALTIMORE** 1 🗌 Yes 2 🎾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6717 CHOKEBERRY ROAD 21209 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces?

1 Yes 2XXNo the Medical Examiner Black White etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XX No Specify: WHITE Specify: 3 Ulidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever ည MORTON BRAGER SARAH YAFFE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau JERRY LITFIN/HUSBAND 6717 CHOKEBERRY ROAD, BALTIMORE, MD 21209 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place HEBREW YOUNG MENS 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/30/2010 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Signature of Funeral Service Licens art 1. Enter the disease, o complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ INTRACRANIAL HEMORRHAGE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ANEURYSM RUPTUR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 Ectopic pregna 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? eral Director; After this certific filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? injury 5 Pending 2  $\square$  No 2 Accident
3 Suicide
4 Homicide Investigation 6 [ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

5

32. Registrar's Signature

~ MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BROWN

HRISTOPHER

AUG 0 2 2010

31. Date filed (Month, Day, Year)

AU4176435B100552

BALTIMORE, MD 21201

GREENE ST SUITE SIZD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 1, Day 2010 Year FRANCES 1:20A JANE MADDEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford 2132 Buell Drive Fallston 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days 1 M 2XXF Months Hours February 7, 1930 Mary Tand **Director** 217-24-0833 80 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director the Medical Examiner must be notified 1 ☐ Yes 2 🏋 Xio Maryland Harford Fallston 10e. Street and Number ò 10f, Zip Code 10g, Citizen of What Country? Funeral "natural", or items 23a 2132 Buell Drive 21047 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXXVo If Yes Give Specify: 3XXWidowed 4 □ Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Angela Anello Samuel Liberto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9717 Denrob Court Baltimore, Maryland 21234 Angela Perrotta DTR 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State Most Holy Redeemer AUG 4, 2010 Baltimore, Maryland Donation 5 C Other (Specify) 22. Name and Address of FMitchell-Wiedefeld Funeral Home Inc gnature of Funeral Serv 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, Part 1. Enter the disease, or complication of tha caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Lung Conce 2 years disease or condition resulting in death) Medical Due to (or as property of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami anding physician and use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဂ္ 1 Yes 2XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hour. The Funeral Dir. 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d, Date signed (Month, Dav. Year)

State Registrar William Waterfield 9103 Franklin Square Drive Suite 2200 Balto MD 21220

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

31. Date filed (Month, Day, Year)

AUG 022010

024356

August 2

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical Name (if not institu give street and number Examiner 10S Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗙 F ODirector 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Funeral Director 1 Yes 2 200 ood awn 10f. Zip Code 10g. Citizen of What Country? 21207 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 Yes If Yes, Give Year or Dates. 1 ☐ Yes 2 Mo Specify: Blac 3 ➤ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) cify only highest grade completed) fay (0-12) College (1-4 or 5+) omesti neer To Be State, Zip Code) 21207 680 Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place Date Location - City 1 Hurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) arrison . Signat of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line. Immediate Cause (Final and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to Expassion section by of Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 1 Ves 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 5 Pending ↑ Natural 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🕊 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signe who completed cause of death (Item 23a) (Type, 30. Name and address of person

Registrar
DHMH 17 Rev 7/2009

State

AUG 02

31. Date filed (Month)

**Physician** 

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Day

Year

DHMH 17 Rev 1/2001

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Physicia Medic				Hideyuki 1	logucl	hi			July	26,	2010	) 1:55 A M
Examin				give street and number)				r Location of Death			ounty of Deat	
,		5. Social Security No			ne (In vrs. Is	ast birthday		esda If Under 24 Hrs.	8. Date of Bin	Montgomery  Birth 9. Birthplace (State or Foreign		
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ems er mu	nne	11. Marital Status		12. Was Decedent			. Was Decedent of H				. Race - Ame	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Marri 3 🏿 Widowed		Armed Forces?  ed 1 X Yes 2 L  If Yes, Give  Year or Dates.		942 <b>-</b> 15	If Yes, specify Cuba 1 ☐ Yes 2 🔀 No		Rican, etc.)	Sp	Black, White ecify: A	e, etc. sian
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permit Depart Impor any in		21. Signature of Fur	neral Service Li	·	м0130	5 F	22. Name and Addre Obert A. Fu 1557 Wiscons	ss of ^{Facility} Fune in Avenue,	eral Home, Bethesda,	Bethes Maryla	sda-Chev and 208	y Chase, Inc. 14-3501
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2 🗌 Feta at time of c	al death 3	☐ Ectopic pregnand ☐ Other (specify)	су		230	d. Date of de Month	livery Day Year
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the Hospit in 24 hour the Funera	Medical	(Check 2	☐ Medical Ex	Physician: To the best of caminer: On the basis of Nurse Practioner: To the	examination	n and/or inve	stigation, in my opini	on, death occurred a	t the time, date a	ind place, an	nd due to the	cause(s) and manner stated.
To with		29b. Signature and	title of certifier	Duan	~	MO	29c. Licens	e number 67634			signed <i>(Montl</i>	
30t)				ho completed cause of .D. 1396 P				ille. Mar	vland 2	0850		
Stat	e	Sandra SV	oonii, m	32. Regist	's Sign	W. Co	ve, Rockv		, , , , , , , , , ,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/  $J_{\mathbf{u}}^{\mathsf{m}} J_{\mathbf{y}}^{\mathsf{m}}$ 25, 2010 4:20 Umeko S. Nichols Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11501 Ashley Drive Rockville Montgomery 5. Social Security Number 1 Year If Under 24 Hrs . Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛚 F (Month, Day, une 27 Months Days Hours Year **Director** 83 214-42-3989 Ju<u>ne</u> Japan Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Directo 1 Yes 2XXNo <u>Maryland</u> Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 11501 Ashley Drive United States "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2XXNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【 No Specify: If Yes. Give Specify: Asian 3 X Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4 Seamstress Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Not Available Not Available 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Jake Nichols/Son 11501 Ashley Drive, Rockville, Maryland item injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of July 31, 20c. Location - City or Town, State Page 1 permit. Page 1 Department of Important: If it any injury or o 1 🗆 Burial 2XXCremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium Bethesda, Maryland 21. Signa o Tuneral Service Live see 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 Maryland 300 West Montgomery Avenue 50-2805 M00803 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Uterine Cancer disease or condition Months Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injuly that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending above. Physician/Medical Box 68760 E FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2424No 3 Ectopic pregnancy Dav 5 Other (specify) Pregnant at time of death 9 Unknown g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2XXNo Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 XXC ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and titl of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37142 July 27, 2010

30 V State

DHMH 17 Rev 7/2009

Registrar

1355 Piccard Drive, Rockville, Maryland

20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Geoffrey Coleman,

31. Date filed (Month. Day, Year

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

signed by t Completed peen 24a. Was an autopsy certificate has performed? page ✓ Yes 2 No : Hospital or Attending Physiciae: 24 hours after death.
: Funeral Director: After this certificately filled in by the funeral director; 25. Was case referred to medical 26.Place of Death (Check only one) å Other₄ Inpatient 2 FR/Outpatient 3 DOA 1 ✔ Yes Nursing Home 5 Residence 6 Other: မ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be To the Hospital o within 24 hours af To the Funeral D determined 4 ___ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa

Assistant Medical Examiner

32. Re

State Registrar

DHMH 17 Rev 1/2001 OCME 2006

31. Date filed (Month

29b. Signature and title of certifier

Pamela E. Southall, MD

30. Name and address of person who completed cause of death (Item 23a)

**ORIGINAL** 

2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

OCME

24b. Were autopsy findings available

death?

1 🗸 Yes

29d. Date signed (Month, Day, Year)

July 22, 2010

prior to completion of cause of

2 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6:20PM Grace Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Davs Hours Min 9/10/1940 Mary land Director 217 38 9160 69 Yrs. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 27 ☐ No Maryland Howard Jessup 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 20794 United States 8405 Hazelwood Ct. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11 Marital Status 14 Bace - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 X Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Office Work Honeywe11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ William Franklin Rose Mae Lee Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melanie B. Search / Daughter 10115 Old Woodland Entry 30022 Alpharetta, GA 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/30/2010 Cedar Hill Cemetery Brooklyn, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A. SE: Glen Burnie, MD 21061 Crain Hwy. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ (0 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) ed by the a detached for Unknown signed t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 💢 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes_2 Nc page 2 s 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending work?
1 Yes 2 No ithin 24 hours after death.

the Funeral Director: Aformpleted filled in by the fu Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 U Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year, Orty, Krnf 25 80

State Registrar 31. Date filed (Month, Day, Year,

AUG 0 2 2010

32. Registrar's Signature

-Chru

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arrow Lewis VUChve va VSUS N-C

		1 State Registrar	l aatl		Cei	rtificate of L	Jeath ————————————————————————————————————	2. Date of Dea	Reg. No. 2	010	+2395		
/sicia		1. Decedent's Name (First, Middle, L Carlton C	harles Pe	rin				Month July	_	20 ÎÖ	7:49pm		
ledic amin		4a. Facility Name (If not institution, g				4b. City, Town, or	Location of Deat		4c. Cou	nty of Deatl	h		
		Northampton Man					derick			Frede			
eral ctor		213-07-5779	. Sex 7. 1 X M 2 □ F	. Age (In yrs. last I	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Aug 14	th y, Year) , 1919	9. Birtl	hplace (State or Fore untry) MD		
al I		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limi		
Deg	tor	MD Fred	erick			Woo	dsboro				1 □ Yes 2√		
enoi	Oire.	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Co	untry?		
	la l	11008A Dublin R	oad				1798		USA				
9	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decede Armed Force 11√2]Yes 2	es?	13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S ın, Mexican, Puerl	Specify Yes or No- to Rican, etc.)		Race - Ame Black, White	rican Indian, e, etc.		
E S	þ	3 ☐ Widowed 4 ☐ Divorced		es:1940-44	.   '	I□Yes 2□No	Specify:		Spe	ecify: WI	nite		
	eted	15. Decedent's (Specify only highest of	Education	16		lent's Usual Occup		rking	16b. Kind o	f Business/I	Industry		
any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	`life. I	DO NOT use retirea	"		Trope	nontoi	tion Dlar		
ř l		17. Father's Name (First, Middle, La.	et)	rive	er and Business Owner Transportation 18. Mother's Name (First, Middle, Maiden Surname)					LIOII, FIAII			
c eve	o Be	· ·	•				TO. MOUTET 3 NAT			iamo)			
I	2	Randolph Perin  Unknown  Pa. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
er ma		Mrs. Sandra Dert	zbaugh (D	aughter)	110	08A Dubli	n Rd., V	loodsbor	o, MD	21798			
r oth		20a. Method of Disposition	[] D C	ceme	of Dispo	sition (Name of natory or other plac	e)	Date	20c. Location	on - City or	Town, State		
nry		1 ☐XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Everg		Mem. Gar			Finks				
once.		21. Signature of Funeral Service Lic	censee /	- //0//7/	22	. Name and Addres	of Facility HA	GHŢ FUN	ERAL, H	OME &	CHAPEL, F		
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between											
		shock, or heart failure. List on Immediate Cause (Final	ly one cause on eac	ch line.			g, such as cardia	o or respiratory a	11001,		Interval Between Onset and Death		
ian cal		disease or condition resulting in death)	d	DEMEA	_	A					54R5		
ner		Due to (or as a consequence of):											
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):											
artialisi	Examiner	that initiated events resulting in death) Last	C	r as a consequenc	o of):								
	_		Due to (or	as a consequenc	e oi).								
	edic		d			-							
n n	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy th 2  Fetal dea	ath all	Ectopic pregnanc	,		23d.	Date of del	ivery		
	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of death		Other (specify)	у			Month	Day Year		
a l	Phy	9 ☐ Unknown  Part II. Other significant conditions			s in the u	adarlying anyon give	an in Port I	23e Did t	obacco use c	contribute to	the cause of death?		
3	by	CAD, WT				44LopA					obably 4 Unkno		
linolic	Completed		<del></del>	1		-1-1-20  -1	·-/	1			itopsy findings availa		
z añ	E I							24a. Was autor perfo	osy rmed?	prior to death?	completion of cause		
, p		25. Was case referred to medical	T				26. Place of Do	1 ☐ Yes ath (Check only o	2 No	1 □ Yes	2 🗗 No		
	o Be	examiner?	Hospital:	patient 2 ER/	Outpatier	nt 3 DOA Othe	ar:	din ( <i>Crieck Only o</i> Home 5 ☐ Resi		Other (Spe	cify)		
<u> </u>	ü	27. Manner of Death 1  Natural 5  Pending	28a. Date of		o. Time of Injury		y at	28d. Describe I					
e I	Certification:	2 Accident investigat	ion			M 1□	Yes 2□No						
	ij	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	Zee. Place of	f Injury - At home, g, etc. (Specify)	farm, str	eet, factory, office		28f. Location (; City or To	Street and Nu vn, State)	ımber or Ru	ural Route Number,		
completely filled in by the funeral director, page 2 should be detached for use as the bur	ह	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. Dont B. C. S. W. 65 C. The May V.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010  $\operatorname{JuIy}^{\scriptscriptstyle{\mathsf{Month}}}$ 24, 1750 James F. Patterson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Center Clinton Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Birthpic Country) DC **Funeral** 1 🗓 M 2 🗆 F Months Davs Hours Min. 12/23/1943 Director 66 579-52-9389 Usual Residence of Decedent 28a-f show 10a. State with the Maryland 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 😾 Yes 2 🗌 No TN Greeneville Greene 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral USA 210 Clem Street 37743 "natural", or items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No 1967-Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No 1969 Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) yrs. AME Zion Church Clergy permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other traumatic event, once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Patterson Catherine Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Sanders-Davis/Cousin Uniondale, New York 768 Dale Place Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🛛 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/30/2010 Triangle, Virginia Quantico National 21. Sigrature of Fundal Service License 22. Name and Address of Facility Marshall March Funeral Home 20011 4217 Ninth Street, NW Washington, DC 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami physician and the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed EUROLIC Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ. Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes the funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital: 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending 2 Accident 1 Yes 2 No Investigation Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by 4 D Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: In the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29c. License number death (Item 23a) (Type, Print) who completed. 02 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Margaret C. Rulli 2010 2:50 A August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Baltimore Towson 8. Date of Birth (Month, Day, Yea Sept. 30, Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔯 F Days Hours Country) Maryland 89 Director 220-14-0066 Yrs 1920 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director must be notified 28a-f 1 ☐ Yes 2 🕱 No MDHoward Ellicott City ö 10e. Street and Numbe 10g. Citizen of What Country? 23a 3649 Valley Road 21042 USA ral", or items? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 ☐ Yes 2 🖾 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. White | Hygiene. other than "natural", Specify: 3 ☒ Widowed 4 ☐ Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F ဂ Helen Buttler Pat Aro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 9226 Spring Valley Road; Ellicott City, MD 21043 Nick Rulli Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadowridge Mem. Park 8/4/2010 Elkridge, MD permit. 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue: Catonsville, MD 21228 Signature of Uneral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ AIZNEWES. disease or condition demention Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate naus. Enter Incardying Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Dav Year sate has been signed by the a page 2 should be detached for g Unknown 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by , type I dovoctes, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 No 2 🗌 No certificate 1 Yes **Division of Vital** To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Descritifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) To the 29b. Signature and title of certifier 29c. License number CENP Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23970 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month HARLES 2010 6:13a JULY Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore 5106 Eugene Avenue 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 3, 1938 9. Birthplace (State or Foreign **Funeral** 1 □**x**M 2 □ F Months Davs Hours Min. ountry) So. Carolina Director 249-54-8790 Usual Besidence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore N/A Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral U.S.A. 21206 5106 Eugene Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian Armed Forces? Black, White, etc. Ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 KNo Specify: If Yes, Give Black Completed 3 Widowed 4 Divorced Year or Dates er than "natura", the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary E. Galloway Flizah Rice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5106 Eugene Avenue Baltimore, Maryland 21206 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th Charles K. Rice 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place Burial 2 Cremation 3 Removal from State Baltimore, Md. 4 Donation 5 Other (Specify) 08/06/10 Western Star Cemetery Signature of Funeral Se Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A 1300 Eutow Place Baltimore, Md 213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final HYPERTENSION ULMONARY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): OBSTRUCTIVE PULMONARY Examine Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) signed by the a 9 Unknown 1 ☐ Yes ∠ L g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 autopsy performed? this certificate has 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at After injury work? 1 Natural 2 Accident 5 Pending 2 🗆 No Investigation within 24 hours after deat To the Funeral Director: completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or inventioning in my printed that Medical 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the only one re and title of certifier 29b. Sigha 29d. Date signed (Month, Day, Year) D64116 and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD 21224; LAURA

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Item 26 per verb., g906,08/02/2010dhb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY Day 2010 Year **JOSEPH** JOHN 26 12:30 PM RAAB Medical 4a. Facility Name (if not institution, give street and number)
FRANKLIN SQUARE HOSPITAL 4c. County of Death IMORE **Examiner** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F 72 Months Days Hours Min. 8-2-1937 216-34-9945 MARYLAND Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ROSEDALE 1 🗆 Yes 2 🗀 No BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U . S . A . Funeral 21237 809 ROSEDALE AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Xes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify: If Yes, Give res, Give Year or Dates. 1960-61 Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TRUCK DRIVER WARD Be 17. Father's Name (First, Middle, Last) NICHOLAS 18. Mother's Name (First, Middle, Maiden Surname) CATHERINE (WEST) RAAB ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship, (Type, Print IRENE B. RAAB/WIFE 809 ROSEDALE AVE ROSEDALE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State SACRED HEART JESUS 7-30-10 DUNDALK, MD 4 ☐ Donation 5 ☐ Other (Specify) gnature of Funeral Service Licenses 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21237 1211 CHESACO AVE ROSEDALE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and I for use as the burial-transit Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Year Month Day 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertenson. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has ral director, page 2 autopsy performed Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No Other: ဂ္ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 🗌 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred After injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 24 hours after death e Funeral Director; A bleted filled in by the fi Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Certifying Physician: to the best of my knowledge, deam occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge, each occurred at the time, date and object and due to the cause(s) and manner stated. (Check within 2 To the F

12 State

DHMH 17 Rev 7/2009

Registrar

29b. Signature and title of certifier

140vald 31. Date filed (Month, Day, Year) au

ATTANA310

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

sed NO

2. Registrar's Signature

29c. License number

29d. Date signed (Month. Day, Year,

21237

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	For State Registrar	State of	r Marylan		tificate of t	Death	ментаг ну	Reg. No.2 0	10	23972	
cian/	Decedent's Name (First, Midd     SAM JOHNNIE ROBER						Date of De     Month		Year	3. Time of Death 0157 a _M	
dical niner	4a. Facility Name (if not institution SOUTHERN MARYLANI	n, give street and numi	*			r Location of Deat		4c. County	y of Death	GES	
al or	5. Social Security Number 247.98.5549		7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.				place (State or Foreign	
ctor	Usual Residence of Decedent  10a. State 10b. Count	· · · · · · · · · · · · · · · · · · ·	10c. City	, Town or Loc					1	I 0d. Inside City Limits 1	
al Director	D.C. 10e. Street and Number			WASHI	10f. Zip Code			10g. Citizen of	lg. Citizen of What Country?		
To Be Completed by Funeral Director	1221 M STREET, NV 11. Marital Status 1 Never Married 2 XX Ma 3 Widowed 4 Divorce	12. Was Deced	dent Ever in U.S ces? 2XX No	If	20002  Vas Decedent of H  Yes, specify Cuba  Yes 2	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)		ce - Americ ck, White, e		
Completed		ent's Education lest grade completed)  College (1-	4 or 5+)	(Give k	NOT use retired)	during most of wo	rking	16b. Kind of E		dustry	
To Be	17. Father's Name (First, Middle, JOHN ROBERTS					DAISY B.			aiden Surname)		
	19a. Informant's Name/Relationship (Type, Print)  SYLVIA FOXWORTH  SISTER  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip.  2708 RAINIER STREET, FLORENCE, SC 29505  20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 ★ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or cemetery, crematory or other place)										
oj l	1 ★ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other  21. Signature of Funeral Service	(Specify)		KSON & I	AUGHTERS (		7 30, 2010	MARI	ON, SC		
5	23a. Part V. Enter the disease, of shock or heart failure. Ust	complications that ca	M01 aused the death	<b>14</b> 8 4	126 CRAIN I	∃WY. S., GL	EN BURNIE		1	Approximate Interval Between	
n/ al er	Immediate Cause (Final disease or condition resulting in death)	V .		ence of):	indial	Swar	tion			Onset and Death	
ledical Examiner	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										
Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	су			ate of delive	ery Day Year					
ρ	Part II. Other significant condit	ions contributing to de	eath but not resu	ulting in the ur	nderlying cause gi	ven in Part I.				he cause of death?	
Completed							24a. Was auto perfo 1 \sum Yes	psy ormed?	Were autor prior to cor death? 1 \( \subseteq \text{Yes} \)	psy findings available impletion of cause of	
Be	25. Was case referred to medica examine?	Hospital:			_ Oth	lace of Death (Che					
icate: To	1  Yes 2  No  Hospital: 1 Inpatient 2  ER/Outpatient 3  DOA  Other: 4  Nursing Home 5  Residence 6  Other (Scr. Manner of Death 1  Natural 5  Pending 2  Accident Investigation									2	
al Certificate:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Ru City or Town, State)									Route Number,	
Medical	(Check 2 🗌 M dical only one) 3 🗀 ertifyir	g Physician: To the be Examiner: On the basi Nurse Practioner: T	s of examination	and/or investi	gation, in my opini eath occurred at th	on, death occurred te time, date and pl	at the time, date a	and place, and dune cause(s) and m	ue to the cau nanner as st	use(s) and manner stated ated.	
	29b. Signature and title of certif	me_		MD	29c. Licens		)	July 2			
	30 Name and address of person	who completed cause	of death (Item	23a) (Type, P	rint)	remy.	SE#3/17	Wash	insto	(2010) nDC 20032	

Registrar
DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of Ma	ryland	-	rtment of l			ental Hy	giene Reg. No	2010		23973
	Physicia		1. Decedent's Name (I Florence			1o					2. Date of De Month July	eath Da 28	8, 2010	- 1	3. Time of Death 0:40 A. M
4	Medi Examir		4a. Facility Name (if no	ot institution, give	street and number)			4b. City, Town, o			July		. County of Dea	ath	
1	Funeral		Stella Ma 5. Social Security Nurr			(In yrs. las	st birthday)	Timo If Under 1 Year	oniun I If Und		8. Date of Bir	th	Balt	irtholac	ce (State or Foreign
	Director		213-01-61	.UL		93	Yrs.	Months Days	Hours	Min.	${ m eb}$ $17$	y, Year	917 Ma	cuntry)	and
	and show dat	ξ	Usual Residence of De 10a. State 1	10b. County		10c. City,	Town or Loc	ation						10d	. Inside City Limits
	Mary 28a-f notifie	Director	Maryland	Balti	more		Towso								1 ☐ Yes 2 🔀 No
	with the 23a or ist be	eral	10e. Street and Number 7925 York					10f. Zip Code 21	204			10g. Ci	tizen of What C		?
	death v items ner mu	Funeral	11. Marital Status		12. Was Decedent Ev Armed Forces?	er in U.S.	13. W	as Decedent of H Yes, specify Cuba		Origin? (Speci	fy Yes or No- can. etc.)		14. Race - Am Black, Whi	erican	
п. 036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by	1 ☐ Never Married 3 🏹 Widowed 4 [		1 ☐ Yes 2 🔀 N If Yes, Give Year or Dates.	lo		☐ Yes 2 🔀 No			,		Specify:Whi		•
а.m. 15-0036	2 hour "natur edical	Completed	(Specif	15. Decedent's Ed fy only highest gra	ducation		(Give k	ent's Usual Occup	durina ma	ost of working	,	16b. K	and of Business	s Indus	try
2010 10:40 Maryland 2121	vithin 7 jiene. er than the M		Elementary/Second	day (0-12)	College (1-4 or 5+	)	life. DC	NOT use retired) Secreta					Citv of	· Ba	ltimore
01 () Pu	e filed v tal Hyg ed othe event,	To Be	17. Father's Name (First	rst, Middle, Last)						ther's Name (	First, Middle,	•			
2010 Maryla	ould be id Men marke matic	-	Stephen 19a. Informant's Name		Kowalski		405 Maille	g Address (Street	Mar	-/		shle			
	d 2 sho alth an alth an 27 is er trau		Lisa Sand		(niece)			River Dr						.ip Coa 2121	
28, nore,	le 1 an t of He If item or othe	KS LON	20a. Method of Dispos		Removal from State	20b. Pla	ace of Dispos	ition (Name of atory or other place		Da			ocation - City o		
JULY 28, Baltimore,	nit. Pag artmen ortant: injury		4 Donation 5  21. Signature of Funer	Other (Specify	y)	Oal		Cemetery		8-3-1			imore,		
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			shock, or heart fa	failure. List only or	olications that caused t ne cause on each line.	he death.							2	Ap In:	oproximate terval Between nset and Death
	Physician/ Medical		Immediate Cause (Fin disease or condition resulting in death)	nai 🗨	a. Due to (or as a			'AILURE							riset and Death
	Examiner	<u>.</u>	Sequentially list cond	ditions,	b. ————										
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P	cate be executed physician and the burial-transit		that initiated events resulting in death) Las	st	Due to (or as a	conseque	ence of):								
209		edical			d										
89	attending p	an/M	IF FEMALE: 23b. Was decedent pre	cyliant	23c. If yes, outcome of 1 ☐ Live Birth 2	pregnan		Ectopic pregnance	cv				23d. Date of de	elivery	
Box.	ne death r the ath	Physician/M	in the past 12 mo 1 ☐ Yes 2 🛣 1 9 ☐ Unknown	No	4 ☐ Pregnant at t 9 ☐ Unknown	time of de	eath 5 🗆	Other (specify)					Month	Da	y Year
STALL s, P.O.	law requires that the de has been signed by the. e 2 should be detached	by P	Part II. Other significa	ant conditions co	ontributing to death but	not resul	lting in the ur	derlying cause giv	ven in Par	rt I.	23e. Did to		use contribute to	o the c	ause of death?
ರ	require	eted									1 -				ly 4 Unknown
FLORENCE ST ital Records,	The law cate has I	Completed								<del></del>	24a. Was autor perfo	osy ormed?	prior to death?	compl	findings available letion of cause of
FLOR Vital F	<b>ician:</b> The certificate ector, pag	BeC	25. Was case referred examiner?	h-	Hospital:					eath (Check o		ZAN		15 Z L	_ NO
_ >	Physic rthis c eral dire	으	1 Yes 2 X N 27. Manner of Death	No	1 ☐ Inpatien 28a. Date of injury	2	R/Outpatient	3 DOA Othe	4 📙 1		e 5 🗆 Resid		M Other (Spec	cify)	HOSPICE
on o	ending eath. or: Afte he fune	Certificate:	2 Accident	5 Pending Investigation		Year)	injury	work	? Yes 2[		d. Describe i	ow injury	y occurred		
Division of	l or Att after d Directe	Certi	4 ☐ Homicide	6 Could not be determined	28e. Place of Injury building, etc.		ne, farm, stre	et, factory, office		28	f. Location (9 City or Tow		d Number or Ru	ıral Ro	ute Number,
	To the Hospital or Attending Physician: The law requires that the death certification within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 (Check 2	Certifying Phys	sician: To the best of m ner: On the basis of exa	y knowled	dge, death or	cured at the time	, date and	d place, and o	due to the ca	use(s) an	d manner as st	ated.	e) and manner stated
8	To the H within 24 To the F complete	Me	only one) 3 X	Certifying Nurs	e Practioner: To the be	est of my l	knowledge, de	eath occurred at the	e time, da	ate and place,	and due to th	e cause(s	s) and manner as te signed (Mont	s stated	d.
	->-0		1	SINCE	DCKNP			R14	979	12		1	28/20	110	)
			/		ompleted cause of dea										
	Sta	te	31. Date filed (Month, L		32. Registrar's			LLEY RD.	TI	MONIUM	<u>MD 2</u>	1093	3		
	Registra	ar	AUG 0 2	2 <b>201</b> 0	Clever &	7. 14	Parke								

0-05585 Vesley Nathanie			or Print in Black Inc Formaryand 80084	delible I Thent o	<b>nk. Ensu</b> i Health ar	re All Co nd Menta	<b>pies A</b> al Hygie	re Leg ne	ible.	2016	1 2207
		1- For State Registrar		ificate o	f Death				J. NO.	010	2397
Physicia Medical Exami		Decedent's Name (First, Middle,L					Mo	ite of Death onth ly 26, 20	Day	Year	3. Time of Death 0701 hrs
~ .		WESLEY NATHAN  4a. Facility Name (if not institution,		1	4b. City, Town, o	or Location of I		y 20, 20		inty of Death	
		St. Agnes Hospital			Baltimore						
Funeral Director			Xex         7. Age (In yrs. last           XM         2         F         75	st birthday) Yrs	If Under 1 Ye Months Da		24Hrs. 8. [ Min.	09/20	1934 1924	YYY) 9. Birt Foreig Co	thplace (State or in untry) <b>VA</b>
w any	ŀ	Usual Residence of Decedent  10a. State 10b. County	10c. City, 7	Town or Locat	ion						10d. Inside City Limits 1 X Yes 2 No
daryland 28a-f show 1 at once.	ğ	MD 10e. Street and Number	BALT	IMORE	10f. Zip Code			110	a Citizon o	f What Cour	
e Mar or 28s	Director							10,	g. Citizen o	y yviiat Coul	iu y :
with th	eral	1916 CEDRIC ROA 11. Marital Status	12. Was Decedent Ever in U.S	5, 13. Wa	2121 as Decedent of H		? ( Specify	Yes or No-	US/		can Indian, Black,
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho njury or other traumatic event, the Medical Examiner must be notified at once.	Fun	Never Married 2 Married 3 Widowed 4 Divorce	1 X Yes 2 No ced If Yes, Give Year		es, specify Cuba	an, Mexican, P			Spec	Vhite, etc.	ACK
ours af	g b	15. Decedent's Education (Specify	or Dates: only highest grade completed)		nt's Usual Occupa	ation (Give kir		one [	16b. Kind o	of Business/I	ndustry
6 172 hc	Completed by	Elementary/Secondary (0-12)	College (1-4 or 5+)	during m	nost of working lif	e. DO NOT us	se retired)				
within grene.	E C	47. 5-45-4-41 (5:	5+	PH	ARMACIST		M /F:	NA:-J-I)- NA		ICINE	
Baltimore, MD 21215-0036 bernit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", njury or other traumatic event, the Medical Ex. miner	Be C	17. Father's Name (First, Middle, La	ist)			18.Mother's			alden Surn	ame)	
212 buld be Menti mark	2 2	MARQIITS SHET.TON  19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Stre	et and Number	er or Rural F	I.EE Route Numb	er, City or	Town, State	, Zip Code)
MD 12 sho th and t 27 is umati		ALICE J. SHELTON	N/WIFE	191	6 CEDRIC	ROAD	BALT	IMORE	, MD	2121	6
ore, ML ss 1 and 2 s of Health au If item 27 her traums	Ī	20a. Method of Disposition  1 XBurial 2 Cremation		lace of Dispos ematory or ot	sition (Name of co	emetery,	Date	•	20c. Locat	ion - City or	Town, State
Pages ment of		4 Donation 5 Other Spec	CE CE		LL CEMET	TERY	8/2/2	010	BAI	TIMOR	E, MD
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral Service Lic						A. M	ORTON	& SO	NS F.H., INC
	Ц	23 Part I. Enter the disease, or co	Morlin		701-31 I				IMORE		21217 Approximate Interval
Physician /Medical Examiner		failure. List only one cause on	each line. a. Hypertensive Atheroscle	rotic Card			ulac of Tesp	iratory arres	st, shock, o	Tileait	Between Onset and Death
	ł		Due to (or as a consequence of) b.	•							
	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of)	:							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequence of)								
outed nd ransit		events resulting in death). Last	d								
OX 68760, ath certificate be execut attending physician and or use as the burial - tra	Physician/Medical	UNPENDED	AMENDED								
Box 68760 e death certificate b the attending physi ed for use as the bu	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregna	ancy						te of delivery	
certification	cian	past 12 months?	1 Live birth  Pregnant at time of dea	th -	etal death 3 ther (Specify)	Ectopic p	regnancy		Mon	th C	Day Year
Box death he atte	ysi	1 Yes 2 No 9 Unkno	wn 9 Unknown	3 01	iner ( <i>Specify)</i>						
P.O.   es that the igned by t		Part II. Other significant condition	s contributing to death but not res	sulting in the o	underlying cause	given in Part	I. 2	,		,	the cause of death?
S, P	q pe	Sarcoid						1 Yes		Seemand	pably 4 🗹 Unknown
Records, The law require	Completed by							24a. Was ar autops	у	prior to c	topsy findings available completion of cause of
Reco	E						1	✓ Yes 2		death? 1 ✔ Ye	es 2 No
ian:	Bec	25. Was case referred to medical examiner?			26.Plac	ce of Death (C	heck only o	ne)			
F Vital Physician r this certi	P	1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 🗸 E			1	Nursing Hon		Residence		
n of ding Pl	on:	27. Manner of Death  1 ✓ Natural 5 Pending	(Month, Day, Year)	28b. Time of		ury at Work? Yes 2 N		Describe ho	ow injury oc	currea	
Division tal or Attendir rs after death. al Director: A	Certification:	2 Accident Investig	ation 280 Place of Injury At hor	ne farm stre				ocation (St	reet and N	umber or Ru	ral Route Number, City
Div talor rs afte led in	it.	3 Suicide 6 Could n  4 Homicide determi	ot be	no, iami, suo	or, ractory, emoc	building, c.c.		or Town, Sta		umber of tra	ran rodio rambor, dity
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To To Com	Medical	29b. Signature and title of certifier	and manner stated.			ise number					nth, Day, Year)
	200	0 -	MAK		O.C	.M.E.			July 27,		
1	}	30. Name and address of person wh	no completed cause of death (Item 2	23a)	1						<del>.</del>
1271		The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon	y Chief Medical Examiner	111 Per	nn Street, Ba	Iltimore, M	D 21201	<u></u>		OCME	
St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	par	1						

Registrar

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Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of I Month	Day Year
/Medic	cal	4a. Facility Name (If not institution, give street and number)	+ARP  JUL  4b. City, Town, or Location of Death	4 19 2010 1803 M 4c. County of Death
Examin	er	The Johns Hopkins Hospital	Baltimore City	NA
Funeral Director		5. Social Security Number 6. Sex $_{1}$ $\bigcirc$ 6. Sex $_{2}$ $\bigcirc$ 7. Age (In yrs. last birthday) $_{3}$ $\bigcirc$ Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of 8. Months Days Hours Min.	Birth Day, Year)  34, 1971  9. Birthplace (State or Foreign Country)  Auny Land
n the Maryland or 28a-f show notified at	tor	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Lo	altimore	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
uth with the 23a or 28g	al Director	10e. Street and Number 5816 Glenkirk Ct	10f. Zip-Code 2/239	10g. Citizen of What Country?
E Bea	by Funeral	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ Specify:	No- 14. Race - American Indian, Black, White, etc.  Specify: Black
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. fifen 27 is marked other than "natural", or lite other traumatic event, the Medical Examiner	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4 or 5+)	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
and 21 I be filed wintal Hygien ed other the	Be	17. Father's Name (First, Middle, Last)	NEMPLOYED  16. Mother's Name (First, Midd	dle, Maiden Surname)
Maryland nd 2 should be file and Mental Hy 27 is marked oth r traumatic event	Тo	19a. Informant's Name/Relationship (Type. Print)  14avriet Shaw  58/	ng Address (Street and Number or Rural Route Num	
<b>o</b> 85 <b>=</b> 5		20a. Method of Disposition 20b. Place of Dispo		20c. Location - City of Town, State  BO DONNO MI
Baltim permit. Par Departmen Important: any injury o			2. Name and Address of Facility Howell 331 Brehms Lo	Bast more, MD 2121-
Physician	¥ 0	23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  a. ASTROINTEST		y arrest, Approximate Interval Between
/Medical Examiner		Duè to (or as a consequence of):		
oruted -transit	Examiner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Use to (or as a consequence or):  c. Due to (or as a consequence of):	CERTIFICATION OF PROVIDENCE	Merch Comme
3760, 4 rate be executed onlysician and the burial-transit	edical E	d.	CERTIFICATION AT	
Division of Vital Records, P.O. Box 68.  To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Physician/Me		□ Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
ds, P.C.	by	Part II. Other significant conditions contributing to death but not resulting in the	. , , ,	d tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown
KA + A     Records, The law requires the has been signed page 2 should be o	Completed		24a. Wa aut per 1 🗆 Yes	topsy prior to completion of cause of death?
etifica ector, ector	Be	25. Was case referred to medical examiner?  1	26. Place of Death (Check only	<del></del>
Physi of rthis or aral dilin	٦: <u>1</u>	27. Manner of Death 28a. Date of Injury 28b. Time o	f 28c. Injury at 28d. Describ	esidence 6 Other (Specify) se how injury occurred
ivision ratending er death.	Certification:	1 Natural 5 ☐ Pending investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 4 ☐ Homicide 6 ☐ Could not be building, etc. (Specify) Injury 28e. Place of injury - At home, farm, str. building, etc. (Specify)		n (Street and Number or Rural Route Number, own, State)
Hospital or Puneral Distribution at Funeral Distribution of Stelly filled in	edical Cer	29a. Certifier (check only one)  Certifying Physician: To the best of my knowledge, death and one content of the basis of examination and/or in and manner stated.		
To the within To the complete	Med	29b. Signature and title of certifier	29c. License number  RES — 000	29d. Date signed (Month, Day, Year)  JULY 19, 2010
3		30. Name and address of person who completed cause of death (Item 23a) (Type, KARTHIK SGRESH		/olfe St, Baltimore, MD, 21287
Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature		
DHMH 17 Rev 1/20		JUL 272010 Jenus J. J.	NAL NAL	

29d. Date signed (Month, Day, Year)

**Physician** 

/Medical

**Examiner** 

Funeral

Director

28a-f show

or items 23a or

"natural"

Health a

Pages 1 ment of H permit, Pages Department of Important: If it any Injury or o

Baltimore, Maryland 21215-0036

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event, the Madical Examiner must be notified at

To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed attending physician and for use as the burial-transit P.O. Box 68760, Records, Division of Vital

within 24 hours after death To the Funeral Director:

Physician/Medical

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Certification: To

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pletely

29a. Certifier

29b. Signature and title

31. Date filed (Month, Day, Year)

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in the past 12 months? 1 ☐ Yes 2 ♣No 9 ☐ Unknown	4 ☐ Pregnant at time of dea				Month Day Year		
Part II Other significant conditions of	ontributing to death but not result		•		e contribute to the cause of death		
Hypertan.	sion nto		<i>()</i> .	1 ☐ Yes 2 <b>1</b> 24a. Was an autopsy performed? 1 ☐ Yes 2 <b>1</b> ☐ No	24b. Were autopsy findings avail prior to completion of cause death?  1 □ Yes 2 □ No		
25. Was case referred to medical examiner?	Hospital:		ath (Check only one)				
1 ☐ Yes 2 🗗 No	1 ☐ Inpatient 2 ☐ E	R/Outpatient 3 🔲 DC	lome 5 ☐ Residence 6 ☐ Other (Specify)				
27. Manner of Death  1	(Month, Day, Year)	28b. Time of lnjury M	8c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury			
3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	28f. Location (Street and City or Town, State)	Number or Rural Route Number,				

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

47867

4701 Randolph Rd #216. FOCKVILLE, MD ZOSSZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 JÜLY 6:30 A M DOROTHY Medical SCHERL IS 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE RALTIMORE MEDICAL CENTE TOWSON Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2🂢 F Hours (Month, Day, Year) 07/26/1932 Director 162-26-5163 DΛ Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No BALTIMORE MD STEVENSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2115 WILTONWOOD ROAD 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes XX No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married by illed within 72 hours after 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) REGISTERED NURSE MFDTCAI Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be f Department of Health and Menta RAYMOND WENTZLER **ESTHER HOENER** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trace once. LORRAINE SCHERLIS/DAUGHTER WELLSPRING CIRCLE. OWINGS MILLS. MDBaltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🏋 Burial 2 🏋 Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MEMORIAL EL PARK: BETH 7/30/2010 RANDALLSTOWN, MD 21. Signature of Fun ral Service 22. Name and Address of Facility SOL LEVINSON & BROS. ROAD 23a. Part 1. Enter the disease, a complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ~ Interval Between Onset and Death Immediate Cause (Final Physician arridin Coretrovascula disease or condition do Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Graenying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Second at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I., 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of After this certificate has funeral director, page 2 s autopsy performed Yes 2 death? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 욘 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2090 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 70 Charles 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Figure All Copies Are Legible.

AMEND ITEM 8 & Sperfff, G90 Ink. Figure All Copies Are Legible.

State of Maryland Department of Health and Mental Hygiene

Amend Item 7 per fn, g913,03 02/2011 dnb 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month / **Physician** Jeffery Taylor /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Good Samaritan Baltimore 8. Date of Birth 1953 (Month, Pay, Year) 4/14/<del>1963</del> 5. Social Security Number 6. Sex 1 M 2 ☐ F If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Min. 57 Yrs. Maryland 215-60-5988 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show Ħ 1X Yes 2 ☐ No ral", or items 23a or 28a-f s Examiner must be notified Director MD N/A Baltimore the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5121 Pembridge Avenue 21215 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes 2 __No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No þ If Yes Give Specify. Specify: Black 3 Nidowed 4 Divorced Year or Dates "natural" Completed item 27 is marked other than "natu other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Residential Counselor NCIA 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle, Ma **Evalina Midgette** <del>Evalena Blandy</del> Maiden Surname) Be 2 should be finance and Mental F John Taylor ၉ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type Print)
Significant
Trevcena Brown/ Other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 5121 Pembridge Avenue Baltimore, MD 21215 3altimore. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages Department of Important: If it any Injury or o H Burial 2 ☐ Cremation 3 ☐ Removal from State 8/5/2010 Lansdowne, Maryland 4 Donation 5 Dother (Specify) Mt. Zion Cemetery 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Faneral Service Licenses 5240 Reisterstown Road Baltimore, Maryland 21215 ner 23a. Part 1 Inter the dis Ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirth, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Intitated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed s certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 ☐ No 2 No 1 □Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir Certification; To this 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature at title of certifier 29d. Date signed (Month, Day, Year) D0069314 who completed cause of death (Item 23a) (Type, Print)
(a) cond (El 3 Waltham Woods Rd Parker II) 30. Name and address of p 31. Date filed (Month, Day, Year) State AUG 0 2 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2010 Hari Prakash Taya1 1:24 A MMedical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sanctuary at Holy Cross Burtonsville Montgomery 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🔀 M 2 🗆 F Months Hours (Month, Day, Year) av 1, 1933 India Director 218-96-4819 77 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Maryland | Prince George's Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20705 4411 Harbour Town Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify: Asian Indian If Yes Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Power Plant College (1-4 or 5+) Elementary/Seconday (0-12) Mechanical Engineer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bishamber Das Taya1 Kalavati Mittal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4411 Harbour Town Drive, Beltsville, Maryland 20705 Rajiv Taya1 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other placel ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 . Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1/ Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Conges time disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner arlens Coronang Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a conse ence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Rehabilitatio Hospital: Other: 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗌 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10V

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

32. Registrar's Signature

Suite 203

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of Maryland / Department of per me, g905,07/30/2010dh Certificate of	Health and Mental Hygiene 2010 23980 Poeath Reg. No.								
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)	2. Date of Death  Month  Day  Pear  3. Time of Death  3. 7 Pear  3. 26 PM								
1000	Medic Examin			or Location of Death  4c. County of Death								
			Onversity of Maryland Madrial courts B  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	ar I If Under 24 Hrs. 8 Date of Birth Q Birthplace (State or Foreign								
	Funeral Director		214-46-1740 1 M 2 M F 67 Yrs. Months Day									
	and show d at	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits								
	e Mary r 28a-f notifie	Jirec	Maryland Anne Arundel Pasadena  10e. Street and Number 110f. Zip Code	1 🗆 Yes 2 💆 No								
	n with th	Funeral Director	10e. Street and Number 214 Circle Road 226 227 229 229 229 229 229 229 229 229 229	21122 10g. Citizen of What Country?								
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married 1 Yes 2 M No	f Hispanic Origin? (Specify Yes or No- iban, Mexican, Puerto Rican, etc.)  No Specify:  14. Race - American Indian, Black, White, etc. Specify:  White								
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lary	should and M is ma raumat			et and Number or Rural Route Number, City or Town, State, Zip Code)								
re, N	and 2 Health tem 27 other to		20a. Method of Disposition 20b. Place of Disposition (Name of	d, Pasadena, Maryland 21122  Date 20c. Location - City or Town, State								
imo	Page ment of tant: If i		1   ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Glen Haven Mem. Park	July 12, 2010 Glen Burnie, Maryland								
Balt	permit Depart Import any inj		21. Signature of Funeral Service License 22. Name and Add 3204 Mounta	ress of Facility McCully-Polyniak Funeral Home P.A. nin Road, Pasadena, Maryland 21122								
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	Examiner	1/1										
	ted I	Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
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Division of Vital Records, P.O.	is that the igned by be detact	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	2501 Bid 1554555 dos 50111 Bid 15 110 Gades of dealin								
ords	require been si should	leted		1 ☐ Yes 2 Solo 3 ☐ Probably 4 ☐ Unknown  24a. Was an 24b. Were autopsy findings available								
3ec	The law ate has bage 2 a	Completed		autopsy performed?    1   Yes 2   No   1   Yes 2   No								
tal	ician: T	Be	examiner?	Place of Death (Check only one)								
of Vi	g Physier this ceral direction	e: To	1 ★ Yes 2 → TVO 1 ★ Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury	ther: 4  Nursing Home 5 Residence 6 Other (Specify)  ury at 28d, Describe how injury occurred								
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Jivis	al or Att s after d I Direct d in by	28f. Location (Street and Number of building, etc. (Specify)										
_	e Hospit 124 hour 9 Funera leted fille	Medical	29a. Certifier (Check only one)  1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 **Independent of the cause (s) and manner as stated.  3 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  3 **Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	To the within To the COMP	_ ,		use number 29d. Date signed (Month, Day, Year)								
				1003041997 7/7/2010								
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Vishal Bhatnagar M.D. 22 South Ga	eene Street, Baltimore, MD, 21201								
	Stat Registra		31. Date filed (Month, Day, Year)  32. Pegistrar's Signature									
			The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HARRIETT PLAISTED WILSON .2010 . 55 Tulv 8 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Baltimore Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birffiplace (State or Foreign **Funeral** Min. 1 □ M 2 🛛 F Months Hours FEB Say, Y WASHINGTON 557-18-2558 Director 90 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director N/A 1 Yes 2 No <u>Maryland</u> BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5506 ROLAND AVENUE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes : 1 ☐ Yes 2 No Specify: WHITE 3 Nidowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Own Residence Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ GEORGE WHEELER PLAISTED GRAVES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALEXANDER D. WILSON 5506 Roland Avenue, Baltimore, MD 21210 (SON) 20a. Method of Disposition 20b. Place of Disposition (Name of cernetery, crematory or other place)
DRUID RIDGE CEMETERY 8/2/2010 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE, MD 21. Signature A Funera Service Diochses TEMEACEWTEDEFELD FUNERAL DO YORK ROAD, BALTIMORE, HOME, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a consequ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tranthat initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by meunson 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Npatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be after death Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying flurne Fractionals To the basis of a yellowlody of the content of the time. Satisfactly large and one to the cause(s) and manner stated. (Check 29b. Signature and title of certifie of death (Item 23a) (Type, Print) Balt more led (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Tyrone Watkins	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Certificate of Death										
Physičian/	1. Decedent's Name (First, Mide	dle,Last)		imodio or i				Reg. N			Time of Death
Medical Examiner	TIRONE J. WAT							15, 2010			1706 hrs
	4a. Facility Name (if not instituti 6006 Amberwood Ro	· •	mber)	^{4k}	. City, Town, o Baltimore	or Location of	Death		4c. County of	Death	
Funeral	5. Social Security Number		7. Age (In yrs. la	ast birthday)	If Under 1 Ye	ar If Under	24Hrs. 8. Dat	te of Birth (M	M/DD/YYYY)	9. Birthpl	lace (State or
Director	215-08-5678	1XM 2 F	25	Yrs.	Months Da		Min.	c. 13,		Foreign	ry) MD
	Usual Residence of Decedent	( <u>///</u>		110.				· 13,	1304		עניז יי
v any	10a. State 10b. County		10c. City,	Town or Location	1						d. Inside City Limit
land f sho	MD		BAL	I'IMORE_						1	X Yes 2 N
tith the Maryland 23a or 28a-f show any notified at once. al Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of Wha	at Country	?
ith the 133 o notifi	6006 AMBERWOO				21206			US			
leath with r items 23 wst be no uneral		larried Armed Fo		S. 13. Was	Decedent of H , specify Cuba	ispanic Origi in, Mexican, I	n? ( Specify <b>Y</b> e Puerto Rican, e	s or No- tc.)	14. Race - White,		Indian, Black,
fter de l'., or ler mu	3 Widowed 4 Di	1 Yes vorced If Yes, Give Year	2 X No	1 N	es 2X N	o specify:			Specify:	BLACI	K
21215-0036 Id be filed within 72 hours after Menal Hygiene. aarked other than "natural", event, the Medical Examiner.  O Be Completed by I	15. Decedent's Education (Spe	ecify only highest grad	e completed)	16a. Decedent's	Usual Occupa	ation (Give ki	nd of work done	e 16b	. Kind of Busi		
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5-0036 ed within 72 hour 1/4 yene. other than "natu the Medical Exan Completed	12TH			NONE					NONE		
215- be filed ntal Hyg rked oth cent, the	17. Father's Name (First, Middle	, ,				1.1111	Name (First, M		en Surname)		
	TYRONE WATKING  19a. Informant's Name/Relations	Ship (Type, Print)		19b. Mailing A	ddress (Stre		RA WILI er or Rural Rou		City or Town,	State, Zir	o Code)
MD d 2 sho	MONICA GANT/C	OUSIN		3.1			APT. #				
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Baltimore, Permit. Pages I at Department of Hee Important: If ite	21. Signature of Funeral Service			22. Nar	ne and Addres	s of Facility	WESLEY	CHAVI	S. JR.	FNR	L. HM.
	wister)	china	2/1	/ -   20	<u>07-09</u> 1	EASTER	N AVE.,	BALT	IMORE,	MD	21231
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Examiner	Immediate Cause (Final discording or condition resulting in death)	a. Hypert  Due to (or as a c			scular	Disea	ise			-	Death
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certif	past 12 months?	I Live bit	th nt at time of dea	th -	death 3 (Specify)	Ectopic p	regnancy	1	Month	Day	Year
by the attentched for us	1 Yes 2 No 9 Uni	known 9 Unknov	vn	J Other	(Specify)						
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tal Rection: The certificate ector, page	25. Was case referred to medica examiner?				26.Place		heck only one)				
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Hospi 24 hou Funer tely fii	29a Certifier	nysician: To the best	of my knowledge	e, death occurred	at the time, da	ate and place	and due to the	e cause(s) a	nd manner a	s stated.	
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director.  Medical Certification: To Be C		miner: On the basis of and manner sta	examination and								use(s)
F S F S	29b. Signature and title of certifie				29c. Licens	e number		29d.	Date signed	(Month, I	Day, Year)
$\lambda$	Carol	Hall	dir		O.C.	M.E.		Jul	y 16, 2010	)	
EN VE VO	30. Name and address of person				not Dair	ore MD c	1201				
0110	Carol Allan, MD Ass 31. Date filed (Month, Day, Year)	sistant Medical E	xamıner 1	11 Penn Str		ore, MD 2	1201				
State Registrar	AUG () 2 20		aliar a Signature	parke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 23983 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 07 DORIS Year 0756 M T 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel 1224 Whetstone Drive Arnold 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign Country)
Vermont 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 Days Hours Min. Months 724/1916 94 Yrs Director 008-09-7728 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🛣 No Arno1d Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 21012 USA 1224 Whetstone Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event one. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elmer C. Bartlett Bertha Mae Calkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane L. Kraus/Daughter 1224 Whetstone Drive, Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State → Cremation 3 M Removal from State ☐ Buriat Center Cemetery 4 Donat 5 Other (Specify) 7/20/2010 Hyde Park, Vermont 22. Name and Address of Facility George P. Kalas Funeral Home . Signatur 2973 Solomons Island Rd. Edgewater, MD 21037 R Part 1. Enter the disease, or complic shock, or heart failure. List only one tions that caused the death. Do not enter the mode of dying Approximate Immediate Cause (Final Onset an e th Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this continued. signed by the attending physician and dbe detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 2 No page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospita Other: 2 No 1 Tyes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniurv 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 4 m

State Registrar

DHMH 17 Rev 7/2009

Name and address of person who

31. Date filed (Month, Day, Year)

GHWAY ANNAPOUSMOZIYOI

ompleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MAW

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 0420 M Year ZUV BREZHI 0 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis <u>Anne</u> Arundel 5. Social Security Number . Age (In vrs. last birthday, If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Months Hours Min. Baltimore, MD 1/27/127/1935 213-32-6637 Director 74 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Ratt: If item 27 is marked other than "natural", or items 23a or 28a-f sho iting or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Crownsville 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1047 Omar Drive 21032 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status Bace - American Indian. Armed Forces? Black, White, etc. 1 X Yes 2 No If Yes, Give 54-56 Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 02 Electrician Electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Charles Albrecht Marie Wells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1047 Omar Drive Crownsville, MD 21032 Joyce M. Albrecht Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 07/13/2010 Glen Burnie, MD . Signature of Funeral Service Licer 22. Name and Address of Facility Hardesty Funeral Home P.A. 23a. Part 1. Enterpre disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nset and Beath Immediate Cause (Final Ptrysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner?
1 □ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending Accident Investigation 2 No 24 hours after deat Funeral Director. Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the I only one) ire and title of ce Date signed (Month, Dav. Year) 10x) Name and address of p ted cause of death (Item 23a) (Type, F

Registrar
DHMH 17 Rev 7/2009

State

Registrar's Signature

6 2010

State of Maryland / Department of Health and Mental Hygien [ ] Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 458 M James Allen Baker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death WMHS Regional Medical Center Allegany Cumberland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. March 15, 1930 West Virginia Director 551-48-6712 80 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Tes 2 X No MD Garrett Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21532 TISA 2292 Finzel Rd. 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White, etc. þ 1 Never Married 2 Married X Yes Baltimore, Maryland 21215-0036 Körean If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: Specify 3 X Widowed 4 Divorced White Completed War I Hygiene. other than "natura ent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Garrett County Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the A once. Roads Department Foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Allen C. Baker Cleda Folk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 884 Finzel Rd., Frostburg, MD 21532 James L. Baker/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) John's Luth. Cem. July 27, 2010 Accident, MD 4 Donation 5 Other (Specify) Signature of Juneral Service 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD d 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIORESPIRATORT ARREST MINUTES disease or condition Medical resulting in death) **Examiner** 40 MINUTES 1 CUTE PULMUNANT Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death signed by the a d be detached f Yes 2 No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 EMPHTSOMA Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No ပု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 5 🗌 Pending 1 Natural 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) JULY 23, DOO 44317 (MARTUAND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21202 (068 NATIONAL MIGINAY LAVALE MARCAND JAMES R- MOEN MO 31. Date filed (Month, Day, Year) Registrar's Signature State **JUL 28 2010** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2010 Charles Stanley Beachy 4:10a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ceci1 755 Ragan Rd. Conowingo 8. Date of Birth

(Month, Day Yea

June 10, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Hours 1 🛣 M 2 🗆 F ear) 1<u>920</u> 378-12-2672 90 Yrs. Director MD Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 X No MD Ceci1 Conowingo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 775 Ragan Rd. 21918 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No
If Yes, Give 10 / 1 -/ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 21215-0036 should be filed within 72 hours after 1 ☐ Yes 2 ☐XNo Specify: "natural", Specify: 3 Divorced 4 Divorced Year or Dates. 1941-45 Completed White the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) 10 Laborer Farm Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Oliver Beachy Arletta Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5833 NW 33rd Ter. Gainesville, FL 32653 Mark Beachy/ nephew Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ABurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brookview Cemetery 7/21/2010 Rising Sun, MD Name and Address of Facility
.T. Foard Funeral Home, P.A.
ll S. Queen St. Rising Sun, 21. Signifure of Funeral Service Licenses 23a. Part 1 Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death rate has been signed by the a page 2 should be detached 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c, Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signa ed (Month/Day, Year) 29d. Date sign 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) SIVA

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Month Year 15.12 PM Shirley Brownlee 07 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Peninsula Regional Medical Ctr. Salisbury Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 C 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 9-6-1936 Days 1 M 2 XF 578-44-8663 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Somerset Westover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7682 Lower Hill Road 21871 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by filed within 72 hours after 1 Yes 2 No Specify. SpecifyWhite 3 Widowed 4 X Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Jenny's College (1-4 or 5+) 12 Cook Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked <u> William H. Sandrus,</u> <u>Evelyn L. Beavers</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paris Curtis, Jr./Son 7682 Lower Hill Road. <u>Westover, MD 21871</u> injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place), LC 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory, : <u>7-16-2010 Dover. DE</u> 22. Name and Address of Facility 917 W. Isabella St. 21. Sig Bennie Smith Salisbury, MD 21801 23a. Part 1. Ento the dease, or complications that caused the death. Do not enter the mole of lying, such as cardiac or respiratory arrest, shock, or her failure. List only one cause on each line. Interval Between Immediate Juse (Final disease or condition Onset and Death Physician/ DEMENTA 2400 V Medical resulting in death) Due to (or as a consequence of) **Examiner** Syeak. EMPHYSENGE Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exami attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: d asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) ____ Day Year Pregnant at time of death reen signed by the should be detached 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 has 2 🗌 No 1 Tes 24 hours after death.

Funeral Director: After this certific eted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ဂ္ 1 🗌 Yes 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29b. Signature and title of certifier who we D051359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Baltimore, Maryland 21215-0036

P,O. Box 68760

Records,

Division of Vital

1415. S. DNISION ST, SALISBURY

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32 Registrar's Signature

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiena For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ JULY 2010 3:20 P.M BAKEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WORCESTER OCEAN PINES CATERED LIVING, 1135 OCEAN PARKWAY 6. Sex Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days (Month, Day, MARCH 12 Hours Min. 1 □ M 2 🗓 F PENNSYLVANIA Director 88 184-14-5901 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No WORCESTER MARYLAND OCEAN CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21842 USA 12922 CENTER DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Yes 2 X No
If Yes, Give
Year or Dates. 1 Never Married 2 Married þ WHITE 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) BOOKKEEPER PHARMACEUTICAL 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ **SEVERA** THEODORE MARY RABA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STARZENSKI/DAUGHTER 12922 CENTER DRIVE, OCEAN CITY, MD 21842 BARBARA 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) DELMARVA 7/17/10 DELMAR, DE 21. Signature of 22. Name and Address of Facility Funeral Service Lic HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE Part I. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Malnutrition disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Dementia Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Congestive Heart Failure Exami burial-transi that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of nding physician use as the burial COPD Physician/Medical yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗡 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 🗌 No 1 Yes 2 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes Assisted Live မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20067827 12010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd

Registrar DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

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Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7 Physician/ 2010 14:17 Frederick Baker Charles Medical 44. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico Salisbury 31553 Har Par Court If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ▼ M 2 □ F Days Hours Min. (Month, Day, Yea, -18-1928 Mary Land Director 81 213-22-4746 Usual Residence of Decedent Fshow 10a, State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 31553 Har Par Court 21804 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1. Marital Status 14. Race - American Indian Armed Forces' Black, White, etc. 1 X Yes 2 No If Yes, Give Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 - Widowed 4 - Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Meat Cutter Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Baker Rada Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra <u> Anna E. Baker - Wife</u> 31553 Har Par Court, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 7-14-2010 Crematory of Delmarva Delmar, Delaware 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one-sause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ FAILURE EW WEEK disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate sause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): attending physician and I for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the al d be detached for Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate Yes 2 N ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes Other: မ 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Director: After this funeral 28a. Date of injury (Month, Day, Year) Certificate: . Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tes 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completed filled hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier R 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Fegistrar's Signatur State 16 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 23990 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010  $A^{M}$ Alexander Bottino 3:15 Michael Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 102 Ridgefield Lane Fruitland Wicomico Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 💢 M 2 🗆 F Months Days Hours Min. (Month, Day New York **Director** Q63-40-5010 63 6-7-1947 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Fruitland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 102 Ridgefield Lane 21826 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married δ 1965 1 ☐ Yes 2 🔀 No Specify: and Mental Hygiene. is marked other than "natural", Specify: White Completed 3 Widowed 4 Divorced 1971 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electronic Assembler Microwave 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Heaith and Men Important: If item 27 is marke any injury or other traumatic. Bottino Marian Navatta Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Ridgefield Lane, Fruitland, Maryland 21826 <u> Ann Bottino - Wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cem-E.S. 7-20-2010 Hurlock, Maryland 21. Signature of Funeral Service Licensee Bounds Funeral Home 22. Name and Address of Facility 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or compli, at ins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ SMALL CELL CANCER RIGHT LUNG disease or condition MINTUS Medical resulting in death) Examiner SLEEP OBSTRUCTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): death certificate be executed the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ Unknown g 🗌 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

Within 24 hours after death.

The Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detanded. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in till opinion, seath occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number M.Q 050929 7-14-10

Registrar
DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

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21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1405

32. Registrar's Signature

JOY MADARANG

JUL 16

31. Date filed (Month, Day, Year)

## 2010 23991

i 0-05458 Scott Douglas B	edr	Please Type or Print in Black Inde ar State of Maryland / Departr					Jible L U I U	2000		
,		1- For State Registrar  Certific	icate of				g. No.			
Physicia Medical Exami		1. Decedent's Name (First, Middle, Last) Scott Douglas Bednar				2. Date of Death Month July 21, 20	Day Year	3. Time of Death 2340 hrs		
		4a. Facility Name (if not institution, give street and number) 519 Druid Hill Avenue	4	b. City, Town, o Salisbury	r Location of Death		4c. County of Deat Wicomico	1		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b	birthday) Yrs.	if Under 1 Year Months Day		_	h(MM/DD/YYYY) 9. Bii Forei /1956			
nd ihow any ee.	ŗ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow  Maryland Wicomico Sal	wn or Locatio					10d. Inside City Limits  1 X Yes 2 No		
ne Maryland or 28a-f show fied at once.	Director	10e. Street and Number 519 Druid Hill		10f. Zip Code 218(	)1	10	g. Citizen of What Cou USA	ntry?		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Modest Examiner must be notified at once.	Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 X Divorced of Fyes, Give Year	If Ye	Decedent of Hi	spanic Origin? ( Sp n, Mexican, Puerto		14. Race - Amer White, etc.	ican Indian, Black, white		
hours af "natural"	ted by	or Dates:	a. Decedent	s Usual Occupa	tion (Give kind of w		16b. Kind of Business/	ndustry		
215-0036 be filed within 72 ntal Hygiene. rked other than ent, the Mosterl	Completed	12 4 17. Father's Name (First, Middle, Last)	lend	ler	40 Mathada Nasa	/Final Middle M	GMAC			
21215-0C uld be filed wit Mental Hygien marked other e event, the M	Be C	Adam Bednar	18.Mother's Name Anne T		aiden Surname)					
Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Mental H Important: If item 27 is marked of injury or other traumatic event, th	2	19a. Informant's Name/Relationship (Type, Print )  Adam Bednar/father	_				per, City or Town, State			
re, N 1 and FHealth Fitem er trau		20a. Method of Disposition 20b. Place 1 Burial 2 Cremation 3 Removal from State crem		ion (Name of ce		Date	20c. Location - City or			
Baltimore, permit. Pages I as Department of Her Important: If ite		4 Donation 5 Other Specify: Sali	sbury	Cremat	2	27/2010	Salisbury			
Balt permit Depar Impor injury	1	Holloway Funeral Service Licensee 22 Name and Address Funeral Home Professional 501 Snow Hill Rd., Salisbury, MD 21								
Physician /Medical (		36a. Part I. Enter the disease, or comblications that cause the death. Do failure. List only one cause on each line  Hypertensive					st, shock, or heart	Approximate Interval Between Onset and Death		
Examiner		Immediate Cause (Final disease or condition resulting in death)  a a Due to (or as a consequence of):						Beaut		
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause								
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Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be existin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burial completely filled in by the funeral director.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnance 1 Live birth 4 Pregnant at time of death 9 Unknown	ncy	23d. Date of deliven Month	day Year					
ires that the d signed by the		Part II. Other significant conditions contributing to death but not resulting ing in the un	derlying cause (	given in Part I.	23e. Did tob	acco use contribute to	the cause of death? ably 4  Unknown			
Division of Vital Records, Isla or Attending Physician: The law requires is after death.  In Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed by					24a. Was ar autops	y prior to oned? death?	topsy findings available ompletion of cause of		
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of Vita ing Physici After this c uneral direc	의	27. Manner of Death 28a. Date of Injury 28b	Outpatient		Other Nursing		tesidence 6 Other	: Scene		
Sion C Attending death. ector: Af	cation	1 X Natural 5 Pending 2 Accident Investigation (Month, Day,Year)	·	1_,	res 2 No					
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined (Specify)	farm, street	tactory, office b	building, etc.	28f. Location (St or Town, Sta	reet and Number or Ru ate)	ral Route Number, City		
o the Ho vithin 24 } o the Fui	Medical	29a. Certifier (Check only one)  2   Medical Examiner: On the basis of examination and/or and manner stated.								
	Ž	29b. Signature and title of certifier		29c. Licens O.C.I			29d. Date signed <i>(Moi</i> July 22, 2010	oth, Day, Year)		
	-	30. Name and address of person who completed cause of death (Item 23a)		Don- Ci-	Dalkins	D 24224				
Str	te	Pamela E. Southall, MD Assistant Medical Examination 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2010	er 111		t, Baltimore, M	D 21201				
Registi	200	JUL 2 8 2010 Lines A	. 490	Charles						

State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Trems 20a-c per fh g906 8-12-10 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Lanston Blakeney July 10. 2010 1216 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1 X M 2 □ F 247-74-4431 65 Director Jan. 1945 South Carolina Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Completed by Funeral Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. and 1 feet and 27 is marked other than "natural", or items 23a or 1 way or other traumatic event, the Medical Exprince must be uny or other traumatic event, the Medical Exprince must be. 5433 C Street SE # 4 20019 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: African 1 ☐Yes 2 No Specify 3 Widowed 4 Divorced American 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lanston Blakeney Ethel Adams ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Vernetta Allred/ Fiancee 5433 C Street # 4 Washington, DC 20019 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of P
Important; if Ite
any Injury or ot: 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4☐ Donation 5 ☐ Other (Specify) 8-5-10 Clinton, Md. Lee's Crematory 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Si ature of Funeral Service I cense 20019 4001 Benning Rd. NE Washington, DC 23a. Part 1. Ever the disease, or complications that caused the shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and burial-tra Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Year Day 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a, Was an autopsy performed2 Yes 2 No 1 □Yes After this certific Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐Yes 2 ☐No investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 7/12/2010 mpleted cause of death (Item 23a) (Type, Print) Hospital Drive Cheverly, MD 20785 3001 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 2 0 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2010 Physician/ July Buck William 11:30 PM Η. 16 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles Genesis of Waldorf Healthcare Waldorf 6. Sex If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 09/24/1932 Pennsylvania 77 Director 211-24-6909 Usual Residence of Decedent 28a-f show 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10a. State 10d. Inside City Limits Director Waldorf Charles 1 Yes 2 X No Marvland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3001 Lovelace Court 20602 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

**XX Yes 2 \sum No 1953If Yes, Give
Year or Dates. 1955 Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White Specify: 3XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Computer Operator Federal Government 12 years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Katherine Sto1tz Harry Buck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Barbara Ε. LaNore / Daughter 3001 Lovelace Ct. Waldorf, Maryland 20602 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 KBurial 2 Cremation 3 Removal from State Maryland Vet. Cemetery 07/27/2010 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. 21. Signature Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death ☐ Yes 2 ☐ No ed by the a detached f Unknown 9 Unknown P.O. nas been signed b 2 Should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, I 1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate has funeral director, page perforn med? 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No ျ 1 Yes 4 X Mursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at X X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu after death Accident Suicide Investigation 3 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, on who completed cause of death (Item 23a) (Type, Print) LINE CENTER WALREST, AND Date filed (Month, Day, Year, 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 3:20 Medical ao 17 4a. Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death Ane 00 119 nolli Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Months 1 🗆 M 2 👺 F Days Hours 67 July Par Year 1943 212-84-6590 DC Director Usual Residence of Decedent Show 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Capitol Heights 1 X Yes 2 No 23a or 28a-f Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral United States 20743 4211 Vine Street 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces2 1 Yes 2 No Black, White, etc. 1 A Never Married 2 Married ò Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: Black "natural", 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 6th Student Vocational School permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Brooks Robert Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 4211 Vine Street Capitol Heights, Md. Mary Inez Rowland/ Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State 22, Suitland, Maryland 4 Donation 5 Other (Specify) Washington National 22. Name and Address of Facility Stewart Funeral Home. . Siar ture of Funeral Servici 4001 Benning Road NE Washington, DC 20019 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Fnt r the disease Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Myorardia Medical Due to (or as a consequence of) Examiner 10/050 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) ☐ Live Birth 2 ☐ Feed as ☐ Pregnant at time of death ☐ Unknown Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year signed by the a d be detached f g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 7 No certificate has page 1 ☐ Yes 2 🛣 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: ျင 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gettifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 064089 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 32, Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 07 Physician/ 2010 10:10 Marjorie Elizabeth Beard Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Charles Charles County Nursing & Rehab. Plata 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
Illinois 1 🗆 M 2 🕱 F Months Days Min. Hours .0/08/1913 Director 96 343-14-4825 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Maryland Director 1 ¥ Yes 2 ☐ No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b. Funeral 12619 Kavanaugh Lane 20715 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces 1 Yes 2 No
If Yes, Give
Year or Dates. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Private Retail Elementary/Seconday (0-12) College (1-4 or 5+) Woodies q Salesperson Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gertrude Williams Earl Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22473 P.O. Box 188 Heathsville, ٧A <u> Linda Ross - Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) incoln Cemetery 07/19/2010 Brentwood, Maryland 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 21. Signature of Funeral Service Licensee Mondomen Brentwood, 3401 Bladensburg Road 23a. Part 1. Enter the disease, or combilications that caused the death. Do shock, or heart failure. List only one cause on each line. he mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi and ue to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 pronths?

1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical Be 26. Place of De h (Check only one) examiner? Hospital: 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 2 No 1 Tyes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🖔 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature f certifie 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2 0 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	1 - State of Maryland / Dep State of Maryland / Dep Registrar Ce	ertificate of Death	vientai Hygier Reg. i	2010	23996	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death	
	Medic Examin		Margaret Louise Cornwell  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	8	4c. County of Deat	h	
. •			Doctor's Community Hospital  5. Social Security Number   16. Sex   17. Age (In yrs. last birthday)	Lanham If Under 1 Year I If Under 24 Hrs.		Prince G		
	Funeral Director		5. Social Security Number  26-84-4816  Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day Year Narch 14,	1954 0K	thplace (State or Foreign Intry) Canoma	
	aryland a-f show iled at	<b>Funeral Director</b>	10a. State 10b. County 10c. City, Town or Le	ocation			10d. Inside City Limits 1 🎇 Yes 2 □ No	
	the Ma or 28a e notii	Dire	Maryland Prince George's Bowie	10f. Zip Code	10g.	Citizen of What Co		
	h with ns 23a nust b	nera	2809 Spangler Lane	US	A			
920	should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	d by Fu	1 Never Married 2 X Married 4 Vac 2 D No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🔏 No Specify:	ecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify:		
24	2 hours "natur edical	Completed	15. Decedent's Education 16a. Dece	edent's Usual Occupation	king 16b	. Kind of Business		
Maryland 21215-0036	vithin 7 liene. rr than the Me	Com	Elementary/Seconday (0-12) College (1-4 or 5+) iife. L	oo NOT use retired) rtment Manager	Gi	ant Food		
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ız	ould be id Men marke matic	_	William Rogers  19a. Informant's Name/Relationship (Type, Print)  19b. Mail	ar Town State 7in	Code			
, N	nd 2 sh salth ar n 27 is er trau		1	ing Address (Street and Number or Rur 2809 Spangler Lane	-		o occue,	
Baltimore,	permit. Page 1 and 2 should be for Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 1 \( \overline{\text{D}}\) Burial 2 \( \overline{\text{Cremation}}\) Cremation 3 \( \overline{\text{Removal from State}}\) Removal from State	matory or other place)		Location - City or		
atim	mit. Pa bartmer bortant injury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	en Burni ns Funer	e, MD al Home			
ñ	Dep Imp any			16000 Annapolis Ro				
	Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a				Approximate Interval Between Onset and Death	
	Medical Examiner	<u>.</u>	resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.	THRONGO C		· A		
	ted Insit	Examiner	if any, leading to miniediate cause. Enter Underlying Cause (Disease or linjury)	- Ancomia				
	cate be executed physician and s the burial-transi	al Exa	that initiated events resulting in death) Last    C. Due to (or as a consequence of):					
760	icate by physic sthe b	ledical	d					
Box 68	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit			☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of del Month	ivery Day Year	
7. Ö.	that the ned by the detach	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?	
rds,	een sig	ted l			1 ☐ Yes		robably 4 Dunknown	
Heco	The law nate has b	Completed			24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of	
Ita	sician: certific irector,	Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital:	26. Place of Death (Chec				
Division of Vital Records,	To the Hospital or Attending Physician: The law requires within 24 hours after death.  To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be	Certificate: To	1	ent 3 🗆 DOA   4 🗀 Nursing H	ome 5 Residence 28d, Describe how inj		ify)	
3 ☐ Suicide 6 ☐ Could not be determined  3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or R City or Town, State)								
	he Hospit in 24 hour he Funera pleted fills	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or inversion only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred a	at the time, date and pla	ce, and due to the	cause(s) and manner stated.	
	To t with To t		29b. Signature and title of certifier	29c. License number $56241$		Pate signed (Month		
1	43		30. Name and address of person who completed cause of death (Item 23a) (Type, AZEEZ AS LOSUM	Print) 8118 Good Lu	ICK ROAD	Lanham,	MD 20706	
0	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. July 16 2010	600d Lu	/			

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Otato of mi	y	Ce	ertificat	e of Deal	th	F	Reg. No	010	239	97		
	Physicia	an	1. Decedent's Name (First, Middle, Last)									Year	3. Time of I	Death		
	/Medic			llins, Jr			41- 07-	Town and an eli	on of Dooth	07	13	2010 ounty of Death	1709	M		
	Examin	er	4a. Facility Name (If not institution,		1+01			Town, or Location				ntgome				
	Funeral		Washington Adventure   6	. Sex 7. Ag		last birthday		akoma Pa 1 Year If Und Days Hou	der 24 Hrs.	8. Date of Birth (Month, Day	h	9. Birth	place (State or intry)	r Foreign		
	Director		579-20-9820	1 <b>½</b> M 2□ F	84	Yrs.	IVIOITIIIS	Day's Hou		11/09/1		1	ington,	DC		
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or L	ocation.						10d. Inside Cit	y Limits		
	Maryi -fsho fieda	į	DC		Ma	shing	ton						1 <b>∑</b> Yes	2 🗌 No		
	h the or 28a	Director	10e. Street and Number		Wa	SHIR	10f. Zij	Code			10g. Citize	en of What Cou	intry?			
	th wit		3000 Yost Place	e, NE				20018				USA				
	er dea tems	Funeral										Yes or No- n, etc.) 14. Race - American Indian, Black, White, etc.				
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Profice Fyaminer must be notified at once.	by F										Specify:				
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2	ithin 7 ne. nan "r	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)						_					
	led w Hygier her th		3 Contract Officer - GSA  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)									ieral G	overnme	ent		
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ore	es 1 a of He fitem		20a. Method of Disposition 1 ☐ Burial 2 🏝 Cremation 3		20b. F	Place of Disp emetery, cre	oosition (Na ematory or	me of other place)		ate	20c. Loca	ation - City or T	own, State			
<u>E</u>	Pages treet of I tant: If Ite		4 ☐ Donation 5 ☐ Other (Spe	ecify)	Ft.	Linco	oln Cı	rematory	7/21	/2010		entwood	-			
Baltimore, Maryland	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Li		Q			nd Address of Fa						С		
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	/Medical		disease or condition resulting in death)	a Due to (or as	a consequ	uence of):	n	neur	MONE				<u> </u>			
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	rtificate be executed ng physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a conseq	uence of):	ren	a c	2/32	ank.						
68760,	e be e			d.												
	rtificat ng phy as th	Medical	IF FEMALE:													
Box	eath cer attendir for use		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Feta	death 3	B ☐ Ectopic				23	3d. Date of deli Month	-	Year		
0	he dea the a	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pregnant a 9 □ Unknown	at time of o	leath 5	☐ Other (s	pecify)					,			
σ.	res that the de signed by the a I be detached I		Part II. Other significant condition	s contributing to death b	out not res	ulting in the	underlying	cause given in Pa	art I.	23e. Did to	obacco us	e contribute to	the cause of d	leath?		
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/ita	cian: sertific	Be (	25. Was case referred to medical examiner?	Line niteli				2.0	lace of Death	(Check only o	ne)					
of	Physic this cral dir	5.	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpati 28a. Date of Inj		ER/Outpati 28b. Time				me 5 Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence Residence R			cify)			
on	ding I h. After funer	tion	1 ⊟Natural 5 □ Pending 2 □ Accident investiga	(Month, Da	ay, Year)	Injury	, м	28c. Injury at Work? 1 ☐ Yes 2		zod. Describe i	iow injury	occurred				
VİSİ	l or Attenoration after death Director; I in by the	Certification: To	3 ☐ Suicide 6 ☐ Could no determin				street, factor	y, office		28f. Location (8 City or Tov		Number or Ru	ıral Route Num	iber,		
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	To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendic completely filled in by the funeral director, page 2 should be detached for use	Medical		Physician: To the best xaminer: On the basis	of examina									5)		
	o the vithin (	Mec	29b. Signature and title of certifier	and manner s			29	c. License numb	per		29d. Date	signed (Montl	h, Day, Year)			
	5		<b>•</b>	4	MO	)		0006	olor		07	-15	-10			
		l	30. Name and address of person w				e, Print)			MD	AUn	120				
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DHMH 17 Rev 7/2009

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JUL 2 0 2010

32. Registrar's

Signatur

		For State Registrar	State o	f Marylar			of Health			giene Reg. No		239	99
Physiciar		1. Decedent's Name (First, Middle, Las Mary Annie Ernest							2. Date of Dea	ath	010 Year	3. Time of 7:15	Death PM
Medica Examine	er	4a. Facility Name (if not institution, give 5400 76th Avenue	street and num			Hyat	vn, or Location	2		4c.	County of Dea	eorge's	
Funeral Director		229-20-3113	ex □ M 2 <b>X</b> □ F	7. Age (In yrs. i	last birthday) Yrs.	If Under 1 \ Months D	Year If Under Days Hours	er 24 Hrs. Min.	8. Date of Bird (Month Da April	th 28,		thplace (State of irginia	
faryland 8a-f show tifled at	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince	George		ty, Town or Lo						-	10d. Inside Cit	ty Limits
with the N 23a or 24 1st be not	Funeral Dir	10e. Street and Number 5400 76th Avenue	ucoi ge	3   10	<u> </u>	10f. Zip Co				10g. Citizen of What Country?			
or or	ě	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced ,	12. Was Dece Armed Fo 1  Yes If Yes, Giv Year or Da	2 💢 No e			of Hispanic C Cuban, Mexic No Specif		cify Yes or No- Rican, etc.)				
within 72 hou giene. er than "natu , the Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)			(Give life. D	dent's Usual O kind of work d O NOT use rei ary An	lone during mo tired)	ost of worki	ng	U.S		Foreign Tech Ce	
ld be filed Mental Hy arked oth atic event	To Be	17. Father's Name (First, Middle, Last)  John Burton Redd	Sr.						e (First, Middle, son Whi		Surname)		
nd 2 shou salth and n 27 is m er traum		19a. Informant's Name/Relationship (T) Richard D. Huskey		end					Route Numbe		Town, State, Z 20784	ip Code)	
Page 1 ar nent of He ant: If iter ıry or oth		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif	Removal from	State	Place of Dispo cemetery, cren lar Hil	natory or othe	r place)		Date /2010		tland.		
permit. Departi Importi any inji		21. Signature of Funeral Service Licens	see		lar Hil 22 1					Eva		ral Hom	e
Physician/		23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on ea	caused the dead sch line. nic Obs						rest,		Approximate Interval Bets Onset and D	ween
Medical Examiner		resulting in death)		(or as a conseq									
e be executed ysician and e burial-transit	Examiner	Sequentially list conditions, If any leading to him data cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):											
cate be ey physician the buria	ical		d							_			
To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the beautied in the funeral director.	Physician/Med	IF FEMALE:   23b. Was decedent pregnant in the past 12 months?   1 ☐ Yes 2 ☑ No   9 ☐ Unknown   1 ☐ Unknown   23c. If yes, outcome of pregnancy   1 ☐ Live Birth 2 ☐ Fetal death   3 ☐ Ectopic pregnancy   1 ☐ Live Birth 2 ☐ Fetal death   5 ☐ Other (specify)   9 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unknown   1 ☐ Unk									23d. Date of delivery Month Day Year		
iires that th signed by Id be detac		Part II. Other significant conditions of	ontributing to d	eath but not re	sulting in the u	inderlying cau	se given in Pa	ırt I.	23e. Did t			o the cause of d	
The law requate has beer page 2 shou	Completed by								24a. Was auto perfo 1 \(\sum \) Yes	psy ormed?	prior to death?	utopsy findings a completion of c	available ause of
ician: certific	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🂢 No	Hospital:		1		26. Place of De		V				
nding Physath. ath. After this e funeral di	icate: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date (Mon	Inpatient 2 of injury th, Day, Year)	28b. Time of injury		Injury at work?		me 5 L Residence 1		Other (Spe	city)	
tal or Atters after destal Directored in by the	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place	of Injury - At h ng, etc. (Specif		eet, factory, o	ffice		28f. Location (S City or Tov			ural Route Numb	er,
he Hospit in 24 hour he Funera ipleted fill	Medical	29a. Certifier 1 X Certifying Phy (Check 2 Medical Examonly one) 3 Certifying Nur	iner: On the bas	sis of examination	on and/or inves	tigation, in my	opinion, death	occurred at	the time, date a	and place	, and due to the	cause(s) and ma	inner stated
To t		29b. Signature and title of certify	<u>e</u>				0701				te signed (Mon	th, Day, Year)	
+10		30. Name and address of person who Ivan Zama, M.D.	9200 Ba	se of death (Iter	n 23a) (Type, F urt Sui	te 200	Largo	MD 2	0774				
Stat Registra		31. Date filed (Month, Day, Year)  JUL 16	2010 ^{32. F}	egistrar's Signa	ature 1	back	,					-	

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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/  $J_{ully}^{\text{Month}}$  17,  $^{\text{Da}}$ 2010 5:07 A Frank Freeman Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 113 Aragona Drive Ft. Washington Prince George's If Under 1 Year | If Under 24 Hrs Social Security Number 6. Sex 1 X M 2 ☐ F **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Hours 80 11970271929 New York Director 059-22-2066 Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at Completed by Funeral Director 10d. Inside City Limits Maryland Prince George's Ft. Washington 1 Yes 2XXNo 5 10f. Zip Code 10g. Citizen of What Country? 23a 113 Aragona Drive 20744 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 x yes 2 No 1946permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event the Mariania. Black, White, etc 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: White 3 🗆 Widowed 4 🗆 Divorced Year or Dates, 1974 Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) vears Lieutenant Commander U.S. Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ Harold Freeman Nellie Dorothy MacDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Remedios M. Freeman / Wife 113 Aragona Drive Ft. Washington, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State txx Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Arlington Nat. Cem. 11/03/2010 Arlington, Virginia 22. Name and Address of Facility George P. Kalas Funeral Hone PA 21. Signature of Funeral Service Licensee 6160 Oxon Hill Road Oxon HIll, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ METASTATIC COLON disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery Live Birth 2 1 1 000.
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year certificate has been signed by the a irector, page 2 should be detached t g 🗌 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Tes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2XXN 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 K XNo Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 XXResidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1XXNatural ☐ Accident 5 Pending 1 Yes 2 No Investigation
6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 XX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certificing Nurse Pranti mer. To the best of my (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 64153 July 19, 2010 h (Item 23a) (Type, Print) 30. Name and address of person who come 8926 Woodyard Road #101 Clinton, Maryland Jose Mendoza MD

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State

Registrar

31. Date filed (Month, Day, Year)

2 0 2010

32. Registrar's Signature